2007 Group Medicare PFFS

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc.

This booklet gives the details about your Medicare health coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. Customer Service:

For help or information, please call Customer Service. (A Customer Service representative will be available to answer your call directly during the Medicare annual enrollment period and 60 days after from 8 am until 8 pm. However, after March 2, 2007, your call may be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call shortly.)

Calls to these numbers are free:

Humana Customer Service
1-866-396-8810

TTY: 1-800-833-3301

Group Benefits Administrator
Kentucky Teachers' Retirement System
1-800-618-1687

Welcome to Humana Group Medicare PFFS

Thank you for your enrollment in Humana Group Medicare PFFS.

Humana Group Medicare PFFS **is a Medicare PFFS plan for people with Medicare.**

Now that you are enrolled in Humana Group Medicare PFFS, you are getting your care through Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. Humana Group Medicare PFFS, a **Medicare PFFS plan**, is offered by Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. (Humana Group Medicare PFFS **is** not **a "Medigap" or supplemental Medicare insurance policy**).

This booklet, together with your enrollment and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of Humana Group Medicare PFFS. It also explains our responsibilities to you.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of Humana Group Medicare PFFS. This booklet gives you the details, including:

- What is covered by Humana Group Medicare PFFS and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave Humana Group Medicare PFFS, including other Medicare options.

If you need to receive this booklet in a different format (such as in Spanish, large print, or audio tape), please call us so we can send you a copy. Section 1 of this booklet tells you how to contact us.

Please tell us how we're doing.

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells you how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with Humana Group Medicare PFFS. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

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Section 1 Telephone numbers and other information for reference

How to contact Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. Customer Service

If you have any questions or concerns, please call or write to Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. Customer Service. We will be happy to help you. (A Customer Service representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 am until 8 pm. However, after March 2, 2007, your call may be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call shortly.)

CALL 1-866-396-8810. This number is also on the cover of this booklet for easy reference. Calls to this number are free.

TTY 1-800-833-3301. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

WRITE HUMANA GROUP MEDICARE PFFS, MEDICARE POLICYHOLDER SERVICES, P.O. BOX 70329, LOUISVILLE, KY 40270-0329

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Health Plans (including Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc.). Here are ways to get help and information about Medicare from CMS:

- Call **1-800-MEDICARE** (1-800-633-4227) toll free to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

SHIP - An organization in your state that provides free Medicare help and information

"SHIP" stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. SHIPs are state organizations paid by the federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage Plan. This also includes special Medigap rights for people who disenroll from a Medigap plan when they enroll in a Medicare cost plan (like Humana Group Medicare PFFS) for the first time, but then leave the cost plan within 12 months and wish to buy another Medigap policy. (Section 11 has more information about your Medigap guaranteed issue rights).

You can find contact information for the SHIP in your state in the state specific data sheets at the end of the Evidence of Coverage. You can also find the Web site for your local SHIP at www.medicare.gov on the Web.

Quality Improvement Organization - A group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. See Section 9 for more information about complaints.

You can find contact information for the QIO in your state in the state specific data sheets at the end of the Evidence of Coverage.

Other Organizations (including Medicaid, Social Security Administration)

Medicaid Agency - A State Government Agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, refer to the state specific data sheets at the end of the Evidence of Coverage.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration toll free at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also visit www.ssa.gov on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY users should call 312-751-4701. You can also visit www.rrb.gov on the Web.

"Group" Coverage

Call the Group's Benefits Administrator (Kentucky Teachers' Retirement System), if you have any questions about your benefits, plan premiums, or the open enrollment season.

Kentucky Teachers' Retirement System
479 Versailles Road
Frankfort, KY 40601
Phone: (502) 848-8500
Toll Free: 800-618-1687

Section 2 Getting the care you need, including some rules you must follow

What is Humana Group Medicare PFFS?

Humana Group Medicare PFFS is a Medicare Advantage Private Fee-For-Service plan. You may go to any eligible doctor or hospital anywhere in the U.S. that is willing to provide care and to whom you have informed, say, by showing them your membership card, that you are a member of Humana Group Medicare PFFS. A doctor or hospital is eligible to furnish your care if they are eligible to be paid by the Medicare program. You can always ask Humana Group Medicare PFFS if you have questions about if a particular service is covered by your plan or if a doctor or hospital can treat you. When you go to a doctor or hospital for non-emergent care, you must inform the provider, say, by showing them your membership card, that you are enrolled in Humana Group Medicare PFFS, a Medicare Private Fee-For-Service plan. If the doctor or hospital decides to treat you, you are only responsible for the cost sharing allowed by your Private Fee-For-Service plan, and normally the doctor or hospital will bill Humana Group Medicare PFFS for the rest of their fee. Some providers may require that you pay your cost share at the time of service, but many will bill you later. Some providers may require you to pay the Medicare allowable amount upfront and you may submit a paper claim to Humana for reimbursement of the Medicare allowable amount less your cost share.

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS and tell us you would like a decision if the service will be covered.

In most cases, use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of Humana Group Medicare PFFS, you have a Humana Group Medicare PFFS membership card.

During the time you are a plan member and using plan services, **you** must **use your plan membership card instead of your red, white, and blue Medicare card to get covered services** . (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but you will not use it to get services while you are a member of a Medicare Advantage Private Fee-For-Service plan. When you go to a doctor or hospital, you must inform them that you are a member of Humana Group Medicare PFFS, a Medicare Private Fee-For-Service plan, and show them your Humana Group Medicare Private Fee-For-Service plan membership card. Your provider will decide if he or she will treat you as a member of a Humana Group Medicare Private Fee-For-Service plan. Providers are not required to furnish services to enrollees in a Private Fee-For-Service plan. If your provider does not want to participate in the Humana Group Medicare Private Fee-For-Service plan, then you must seek care from another provider who is willing to furnish services.

If you get covered services using your red, white, and blue Medicare card instead of your Humana Group Medicare PFFS membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Humana Group Medicare PFFS membership card with you at all times. You will need to show this card when you get covered services. If your membership card is ever damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Help us keep your membership record up-to-date

Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. has a membership record about you as a plan member. Doctors and hospitals use this membership record to know what services are covered for you. The membership record has information from your initial enrollment, including your address and telephone number. It shows your specific Humana Group Medicare PFFS coverage and other information. Section 8 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting your Group Benefits Administrator (Kentucky Teachers' Retirement System) know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in health insurance coverage you have from other sources, such as from your spouse's employer, workers' compensation, Medicaid, or liability claims, such as claims from an automobile accident. See Section 1 for how to contact Customer Service.

What is the geographic service area for Humana Group Medicare PFFS?

In order to enroll in Humana Group Medicare PFFS, your permanent residence must be in its geographic service area. However, members of Humana Group Medicare PFFS may obtain care from any certified provider in the U.S. who is willing to accept Humana Group Medicare PFFS' terms and conditions of payment, whether or not these providers are located in the geographic service area and whether or not these providers directly contract with Humana Group Medicare PFFS.

You are eligible for Humana Group Medicare PFFS through your former or current Group. Your Group's corporate office must be located in one of the following states: Alabama, Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, West Virginia, Wisconsin and Wyoming.

Getting care from doctors, specialists and hospitals

You can receive care from any doctor, specialist or hospital in the U.S. who is eligible to be paid by Medicare and accepts Humana Group Medicare PFFS' terms and conditions of payment. Humana Group Medicare PFFS covers you for all Medicare Part A and Part B services, and the supplemental benefits described in this document. You may also receive renal dialysis (kidney) services from any dialysis provider in the U.S. who is eligible to be paid by the Medicare program. If a particular provider does not accept your plan's terms and conditions of payment, you must seek care from another provider who will. If you have any questions about what services Humana Group Medicare PFFS covers or if a particular provider can be paid by Humana Group Medicare PFFS, you can contact us (see Section 1 for telephone numbers).

Getting care when you travel or are away from the plan's service area

You may go to any eligible doctor or hospital in the U.S. that is willing to provide care and accepts Humana Group Medicare PFFS' terms and conditions of participation. If you require dialysis services, you may go to any dialysis provider in the U.S. that is eligible to be paid by Medicare and accepts Humana Group Medicare PFFS' terms and conditions of payment. When you go to a doctor or hospital, be sure to show them your Humana Group Medicare PFFS membership card. The card ensures that the provider has a reasonable opportunity to obtain the terms and conditions of payment under the plan. (If the doctor or hospital decides to treat you, you are only responsible for the cost sharing allowed by your Private Fee-For-Service plan, and normally the doctor or hospital will bill Humana Group Medicare PFFS for the rest of their fee. Some providers may require that you pay your cost share at the time of service, but many will bill you later. Some providers may require you to pay the Medicare allowable amount upfront and you may submit a paper claim to Humana for reimbursement of the Medicare allowable amount less your cost share). You can call Humana Group Medicare PFFS in advance of receiving health care services and we will provide an advance coverage determination for the care you need. You may also ask us for a coverage decision in writing confirming if the service will be paid for by Humana Group Medicare PFFS.

What if your doctor will not furnish your care as a member of Humana Group Medicare PFFS?

Sometimes a doctor, specialist, hospital, clinic, or other provider you are using might decide to not participate in Humana Group Medicare PFFS. This could occur because your doctor has decided to not accept Humana Group Medicare PFFS' terms and conditions of payment, even though the fee schedule is the same as Original Medicare. If this happens, you will have to switch to another provider who is willing to treat you as a member of Humana Group Medicare PFFS or you may continue to use the same provider as long as they are willing to accept your cash payment of the Medicare allowable amount and you are willing to submit a paper claim to Humana for reimbursement (less your cost share). If you need help finding a provider who will accept Humana Group Medicare PFFS' terms and conditions of payment, please contact us (See Section 1 for telephone numbers) and we will provide assistance.

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when **you reasonably believe that your health is in serious danger** - when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting worse.

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency hospital or urgent care center. **You do not need to get approval or a referral first from your PCP (Primary Care Physician) or other plan provider.** (Section 2 tells about your PCP and plan providers.) Keep in mind, you can receive care from any doctor, specialist or hospital in the U.S. who is eligible to be paid by Medicare and accepts Humana Group Medicare PFFS terms and conditions of payment. Humana Group Medicare PFFS covers you for all Medicare Part A and Part B services and the supplemental benefits described in this document.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world.
- **Ambulance** services are covered in situations where other means of transportation anywhere in the world would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care - thinking that your health is in serious danger - and the doctor may say that it was not a medical emergency after all. If you decide to get follow-up care from the provider treating you as soon as possible, you should advise them of your enrollment in Humana Group Medicare PFFS. Your plan will pay for all medically necessary plan covered services furnished by the provider.

Humana Group Medicare PFFS covers non-emergent care that you get from any provider in the U.S. to whom you have informed, say, by showing your membership card, that you are a member of Humana Group Medicare PFFS.

Section 4 Benefits chart

A list of the covered services you get as a member of Humana Group Medicare PFFS

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of Humana Group Medicare PFFS. **"Covered services" means the medical care, services, supplies, and equipment that are covered by** Humana Group Medicare PFFS. This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are** not **covered** (these are called "exclusions"). Section 5 also tells about limitations on certain services.

You can get covered benefits from any provider qualified to furnish the benefit in question and who is willing to accept Humana Group Medicare PFFS' terms and conditions of payment. We urge you to call Customer Service at the phone number in Section 1 to ask if a particular service is covered by your plan. Your plan does not have to pay for services that are not covered by the plan.

There are some conditions that apply in order to get covered services

Some general requirements apply to all covered services

The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.

- You can get covered benefits from any provider qualified to furnish the benefit in question and who is willing to accept Humana Group Medicare PFFS' terms and conditions of payment (the same as Original Medicare), or they are willing to accept your cash payment of the Medicare allowable amount and you are willing to submit a paper claim to Humana for reimbursement (less your cost share). If you have any questions about what services Humana Group Medicare PFFS will pay for, we urge you to call Customer Service (See Section 1 for telephone numbers) to ask if a particular service is covered by Humana Group Medicare PFFS. Your plan does not have to pay for services that are not covered by the plan.

- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 13 for a definition of "medically necessary".)

Benefits Chart - A list of covered services

Deductible: You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Benefits Chart - Your Covered Services	
Inpatient Services	
Inpatient hospital care For more information about hospital care, see Section 6. You are covered for an unlimited number of days. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy services. • Under certain conditions, the following types of transplants are covered: Corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 6 for more information about transplants. All transplant services must be performed in a facility that is Medicare approved. For more information call 1-866-421-5663 (Humana Transplant Management) Monday - Friday, 8:30 am - 5 pm EST. For corneal transplants call 1-877-511-5000. • Blood - Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Physician Services.	YOU PAY $250 PER ADMISSION. YOU WILL ONLY BE CHARGED THE COPAYMENT ONCE IN A 60 DAY BENEFIT PERIOD. IN ADDITION, YOU PAY 4% COINSURANCE FOR PHYSICIAN'S SERVICES RECEIVED AT A MEDICAL OR SURGICAL FACILITY.

Inpatient mental health care Includes mental health care services that require a hospital stay. THERE IS A 190-DAY LIFETIME LIMIT FOR INPATIENT SERVICES IN A PSYCHIATRIC HOSPITAL. THE 190-DAY LIMIT DOES NOT APPLY TO MENTAL HEALTH SERVICES PROVIDED IN A PSYCHIATRIC UNIT OF A GENERAL HOSPITAL. • Physician Services.	YOU PAY $250 PER ADMISSION. YOU WILL ONLY BE CHARGED THE COPAYMENT ONCE IN A 60 DAY BENEFIT PERIOD. IN ADDITION, YOU PAY 10% COINSURANCE FOR PHYSICIAN'S SERVICES RECEIVED IN A MENTAL HEALTH IN PATIENT FACILITY.
Skilled nursing facility care For more information about skilled nursing facility care, see Section 6. You are covered for 100 days per benefit period. Prior hospital stay is not required. (A benefit period begins the day you go to a skilled nursing facility. The benefit period ends when you have not received skilled nursing care for 60 days in a row.) Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	YOU PAY NOTHING FOR DAYS 1-20. YOU PAY $24 PER DAY FOR DAYS 21-100.

Home health care For more information about home health care, see Section 6. Home Health Agency Care: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	YOU PAY NOTHING.
Hospice care For more information about hospice services, see Section 6. • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit.	WHEN YOU ENROLL IN A MEDICARE-CERTIFIED HOSPICE, YOUR HOSPICE SERVICES ARE PAID BY MEDICARE (SEE SECTION 6 FOR MORE INFORMATION ABOUT HOSPICE SERVICES).

Deductible: You have a $150.00 deductible that must be met before the copayments or coinsurances listed below would apply. **Annual out-of-pocket maximum:** $1,200 per calendar year. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.	**What you must pay** when you get these covered services
Outpatient Services	
Physician services, including doctor office visits	
• Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services. • Non-routine dental care provided by a dentist (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor). • Chemotherapy services. • Drugs administered in a physician's office.	YOU PAY A 4% COINSURANCE FOR EACH PHYSICIAN'S OFFICE VISIT. YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.
Chiropractic services • Manual manipulation of the spine to correct subluxation.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.
Podiatry services • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.

Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	YOU PAY A 10% COINSURANCE FOR EACH PHYSICIAN'S OFFICE VISIT. YOU PAY A 10% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT. YOU PAY 10% FOR EACH PARTIAL HOSPITALIZATION. YOU PAY 10% FOR EACH OUTPATIENT HOSPITAL VISIT.
Outpatient substance abuse services	YOU PAY A 10% COINSURANCE FOR EACH PHYSICIAN'S OFFICE VISIT. YOU PAY A 10% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT. YOU PAY 10% FOR EACH PARTIAL HOSPITALIZATION. YOU PAY 10% FOR EACH OUTPATIENT HOSPITAL VISIT.

Outpatient surgery	YOU PAY A 4% COINSURANCE FOR NON-SURGICAL VISITS AT AN OUTPATIENT HOSPITAL AND A $125 COPAYMENT FOR SURGICAL VISITS AT AN OUTPATIENT HOSPITAL. YOU WILL ONLY BE CHARGED THE $125 COPAYMENT ONCE IN A 60 DAY BENEFIT PERIOD.
Ambulance services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	YOU PAY A 4% COINSURANCE PER DATE OF SERVICE.
Emergency care For more information, see Section 3. THIS COVERAGE IS WITHIN THE U.S. OR WORLD-WIDE.	YOU PAY A 4% COINSURANCE FOR EACH VISIT TO THE EMERGENCY ROOM UP TO A $50 MAXIMUM. EMERGENCY ROOM COPAYMENT IS NOT WAIVED IF YOU ARE ADMITTED TO THE HOSPITAL. YOU PAY A 4% COINSURANCE FOR EACH VISIT TO AN IMMEDIATE CARE CENTER.

Urgently needed care For more information, see Section 3. THIS COVERAGE IS WITHIN THE U.S. OR WORLD-WIDE.	YOU PAY A 4% COINSURANCE FOR URGENT CARE IN ALL SETTINGS.
World wide coverage (for care that is not urgent or emergent)	YOU PAY 20% COINSURANCE UP TO A MAXIMUM ALLOWABLE PLAN BENEFIT OF $5,000. EMERGENCY SERVICES DO NOT APPLY TO MAXIMUM ALLOWABLE PLAN BENEFIT, BUT DOES APPLY TO THE MAXIMUM OUT-OF-POCKET. WORLD WIDE COVERAGE FOR CARE THAT IS NEITHER URGENT NOR EMERGENT DOES NOT APPLY TO THE MAXIMUM OUT OF POCKET.
Outpatient rehabilitation services (Physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	YOU PAY A 4% COINSURANCE IN ALL SETTINGS.
Durable medical equipment and related supplies This includes wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	YOU PAY 4% COINSURANCE.
Prosthetic devices and related supplies (other than dental) which replace a body part or function These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see "Vision Care" for more detail.	YOU PAY 4% COINSURANCE.

Diabetes self-monitoring, training and supplies For all people who have diabetes (insulin and non-insulin users). • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per plan year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. • Self-management training is covered under certain conditions. • For persons at risk of diabetes: Fasting plasma glucose tests, as often as is medically necessary.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Medical nutrition therapy For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Outpatient diagnostic tests and therapeutic services and supplies • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood - Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	YOU PAY A 4% COINSURANCE FOR ALL SERVICES EXCLUDING OUTPATIENT LAB SERVICES. YOU PAY NOTHING FOR ALL OUTPATIENT LAB SERVICES ONCE YOUR DEDUCTIBLE HAS BEEN MET.

Preventive Care and Screening Tests

Bone mass measurements • For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, the following are covered: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Immunizations	
• Pneumonia vaccine.	YOU PAY NOTHING.
• Flu shots, once a year in the fall or winter. As explained in Section 2, you can get this service on your own (as long as you get the service from a plan provider).	YOU PAY NOTHING.
• If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET
• Other vaccines if you are at risk.	YOU PAY 4% ONCE YOUR DEDUCTIBLE HAS BEEN MET

Mammography screening (As explained in Section 2, you can get this service on your own, without a referral from your PCP): • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Pap smears, pelvic exams, and clinical breast exam For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. If you are at high risk of cervical cancer, or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	YOU PAY NOTHING ONCE YOUR DEDUCTIBLE HAS BEEN MET.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease).	YOU PAY A 4% COINSURANCE FOR CARDIOVASCULAR DISEASE TESTING.

Other Services	
Physical exams One physical examination per year.	YOU PAY NOTHING WHEN NO OTHER SERVICES ARE PROVIDED. YOU PAY 4% IF OTHER SERVICES ARE PROVIDED.
Renal Dialysis (Kidney) • Outpatient dialysis treatments. • Inpatient dialysis treatments (if you are admitted to a hospital for special care. • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).	YOU PAY A 4% COINSURANCE PER SESSION FOR OUTPATIENT RENAL DIALYSIS SERVICES.

Prescription Drugs

THAT ARE COVERED UNDER ORIGINAL MEDICARE. THESE DRUGS ARE COVERED FOR EVERYONE WITH MEDICARE. "Drugs" includes substances that are naturally present in the body, such as blood clotting factors.

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services. Humana Group Medicare PFFS also covers some drugs that are "usually not self-administered" even if you inject them at home.
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Humana Group Medicare PFFS.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen) or Epoetin Alfa, and Darboetin Alfa (Aranesp).
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.

YOU PAY 4% FOR PART B DRUGS AT A RETAIL PHARMACY AND 4% FOR DRUGS ADMINISTERED IN A PHYSICIAN'S OFFICE.

PLEASE CONTACT YOUR GROUP BENEFITS ADMINISTRATOR (KENTUCKY TEACHERS' RETIREMENT SYSTEM) FOR ADDITIONAL PHARMACY BENEFITS (IF APPLICABLE).

Additional Benefits	
Dental services • Services by a dentist limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.
Hearing services • Diagnostic hearing exams (non-routine).	YOU PAY A 4% COINSURANCE FOR DIAGNOSTIC EXAMS.
Vision care • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	YOU PAY A 4% COINSURANCE FOR EACH SPECIALIST'S OFFICE VISIT.

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered as a member, we want to help. Please call us at Customer Service at the telephone number in Section 1. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 9 for information about making a complaint.

Can your benefits change during the year?

Generally, your benefits will not change during the year. The Medicare program does not allow us to decrease **your benefits during the plan year**. We are allowed to decrease your benefits only on January 1, at the beginning of the next plan year. The Medicare program must approve any decreases we make in your benefits. We will tell you in advance if there are going to be any increases or decreases in your benefits for the next plan year.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes.

Section 5 Medical care and services that are NOT covered or are limited (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by Humana Group Medicare PFFS. The list below tells about these exclusions and limitations. The list describes services that are not covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 9 and 10).

What services are not covered or are limited, by Humana Group Medicare PFFS?

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS and tell us you would like a decision if the service will be covered.

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are not covered except as indicated by Humana Group Medicare PFFS:**

1. Services that are not covered under Original Medicare, unless such services are specifically listed as covered in Section 4.
2. Services that are not reasonable and necessary according to the standards of Original Medicare, unless these services are otherwise listed by Humana Group Medicare PFFS as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
3. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).

4. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or unless, for certain services, the procedures are covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Humana Group Medicare PFFS and Original Medicare to not be generally accepted by the medical community. See Section 6 for information about participation in clinical trials while you are a member of Humana Group Medicare PFFS.
5. Surgical treatment of morbid obesity, unless medically necessary and covered under Original Medicare.
6. Private room in a hospital, unless medically necessary.
7. Private duty nurses.
8. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
9. Nursing care on a full-time basis in your home.
10. Custodial care is not covered by Humana Group Medicare PFFS, unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
11. Homemaker services.
12. Charges imposed by immediate relatives or members of your household.
13. Meals delivered to your home.
14. Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance, unless medically necessary.
15. Cosmetic surgery or procedures, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
16. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
17. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.
18. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
19. Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

20. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").
21. Hearing aids and routine examinations.
22. Routine eye examinations and eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
23. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
24. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
25. Acupuncture.
26. Naturopath services.
27. Services provided to veterans in **V**eteran's **A**ffairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under Humana Group Medicare PFFS, we will reimburse veterans for the difference. Members are still responsible for the Humana Group Medicare PFFS cost sharing amount.

Section 6 Hospital care, skilled nursing facility care, and other services

(This section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4.)

Hospital care

If you need hospital care, you can obtain care from any hospital in the U.S. that is eligible to be paid by Medicare and willing to accept the plan's terms and conditions. Covered services are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

What happens if you join or drop out of Humana Group Medicare PFFS during a hospital stay?

If you either join or leave Humana Group Medicare PFFS during an inpatient hospital stay, please call Customer Service at the telephone number listed in Section 1. Customer Service can explain how your services are covered for this stay, and what you owe to Humana Group Medicare PFFS, if anything, for the periods of your stay when you were and were not a plan member.

Skilled nursing facility care (SNF care)

Covered services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services.** It can be a separate facility, or part of a hospital or other health care facility. A **S**killed **N**ursing **F**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities, such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF. If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS (see Section 1 for telephone number) and tell us you would like a decision if the service will be covered.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Humana Group Medicare PFFS, unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, Original Medicare will still pay for covered physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

Please also note that if you are receiving SNF services out of plan, and paying Original Medicare out-of-pocket amounts for the SNF services, you will have to pay Original Medicare out-of-pocket amounts for other services you get while you are in the SNF.

What happens if you join or drop out of Humana Group Medicare PFFS during a SNF stay?

If you either join or leave Humana Group Medicare PFFS during a SNF stay, please call Customer Service at the telephone number listed in Section 1. Customer Service can explain how your services are covered for this stay, and what you owe to Humana Group Medicare PFFS, if anything, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound** . This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home, except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.

3. The home health agency caring for you must be approved by the Medicare program.

4. You must need at least one of the following types of skilled care:

   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are <u>also</u> getting skilled care

As long as some qualifying skilled services are also included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are also getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services and home health aide services:

- "**Part-time** " or "**Intermittent** " means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS (see Section 1) and tell us you would like a decision if the service will be covered.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of Humana Group Medicare PFFS, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Customer Services at the number in Section 1 to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at the state specific number listed below.

Region	States in Region	Phone Number
Region I	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont	207-822-7000
Region IV	Kentucky, North Carolina, South Carolina, Tennessee, Alabama, Florida, Georgia, Mississippi, Arkansas, Louisiana, New Mexico, Oklahoma, Texas, Illinois, Indiana, and Ohio	803-788-3860
Region V	Alaska, Arizona, California, Hawaii, Idaho, Oregon, Nevada, Washington, Northern Mariana Islands, Guam, and American Samoa	414-226-6203
Region VII	Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia	205-988-2100
	Puerto Rico	787-758-9733

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Humana Group Medicare PFFS) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through Humana Group Medicare PFFS. If you use non-plan providers for your routine care, Original Medicare (rather than Humana Group Medicare PFFS) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare Web site at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the Web site.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). For more information call 1-866-421-5663 (Humana Transplant Management) Monday-Friday 8:30 am - 5 pm EST. The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial. There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Medicare (not Humana Group Medicare PFFS) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Humana Group Medicare PFFS and continue to get the rest of your care that is unrelated to the clinical trial through Humana Group Medicare PFFS.

You will have to pay Original Medicare co-insurance for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in Humana Group Medicare PFFS. For instance, you will be responsible for Part B co-insurance - generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called "Medicare & You." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web. Section 1 tells you more about how to contact the Medicare program and about Medicare's Web site.

You do not need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do not need to be plan providers. However, please be sure to **tell us before you start a clinical trial,** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and what your costs for those services will be. For more information please contact Customer Service (see Section 1).

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by Humana Group Medicare PFFS under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state, or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Humana Group Medicare PFFS, or your stay in the RNHCI may not be covered.

Note: To verify coverage and your cost sharing responsibility in a religious non-medical health care institution you or your provider should contact Humana Group Medicare PFFS for an advance determination of coverage.

Section 7 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a member of Humana Group Medicare PFFS

To be a member of Humana Group Medicare PFFS, you must continue to pay your Medicare Part B premium. You also may have a Humana Group Medicare PFFS premium that you must pay.

How much is your monthly plan premium and how do you pay it?

Please call your Group Benefits Administrator (Kentucky Teachers' Retirement System) for more information about paying premiums.

What happens if you don't pay your plan premiums, co-payments, co-insurance, or deductibles, or don't pay on time?

If your plan premiums are past due or you have not been paying your co-payments or co-insurance, we will disenroll you from your Group Plan. You will then have Original Medicare coverage (Section 11 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in Humana Group Medicare PFFS, or to enroll in another plan offered by Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc., you will have to pay any past-due plan premiums that you still owe from your previous enrollment in Humana Group Medicare PFFS.

Paying your share of the cost when you get covered services

What are "co-payments," "co-insurance," and "deductibles"?

A "**co-payment** " is a payment you make for your share of the cost of certain covered services you receive. A co-payment is **a set amount per service.** You pay it when you get the service. The Benefits Chart in Section 4 gives your co-payments for covered services.

"Co-insurance" is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is a percentage of the cost of the service. You pay your co-insurance when you get the service. The Benefits Chart in Section 4 gives your co-insurance for covered services.

"Deductible" is the amount you must pay for the health care services you receive before Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. begins to pay its share of your covered services. Your deductible for this plan is $150. Your plan deductible applies to all services except inpatient hospital and skilled nursing facility services.

What is the most you will pay for covered care?

There is a limit to how much you will have to pay for your covered health care each year. During the year, if the amount that you spend on your co-payments and co-insurance as a member of Humana Group Medicare PFFS goes over $1200 we will begin to pay for all of your covered health care. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.

You must pay the full cost of services that are not covered

If you receive services from a certified provider that does not accept the terms and conditions of payment for Humana Group Medicare PFFS, but informed this provider that you are enrolled in Humana Group Medicare PFFS - for example, you showed the provider your membership card - then this provider is deemed to have accepted the terms and conditions of payment and is bound by the plan's terms and conditions of payment. A provider is deemed to have accepted the terms and conditions of payment even if they didn't verbally acknowledge that they were accepting the plan's terms and conditions of payments, and even if they didn't look up (but had access to) the details of these terms and conditions of payment.

However, if you receive services from a certified provider that does not accept the terms and conditions of payment for Humana Group Medicare PFFS and this provider was not informed, and did not know, that you are enrolled in Humana Group Medicare PFFS, then you must pay original Medicare out-of-pocket amounts if you receive Medicare-covered services that are not for the care of a medical emergency, urgently needed care, or services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS (see Section 1 for telephone number) and tell us you would like a decision if the service will be covered.

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service**. For example, you have to pay the full cost for screening mammograms if you receive more than one every 12 months. You can call Customer Service when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using all **of your insurance coverage**

If you have other health insurance coverage besides Humana Group Medicare PFFS, it is important to use this other coverage in combination with your coverage as a member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides Humana Group Medicare PFFS, and let us know whenever there are any changes in your additional insurance coverage. The types of additional insurance you might have include the following:

- Coverage that you have from a spouse's employer.
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.

- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires groups with 20 or more group members to let group members and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

Who pays first when you have additional insurance?

How we coordinate your benefits as a member of Humana Group Medicare PFFS with your benefits from other insurance depends on your situation. If you have other coverage, you will often get your care as usual through Humana Group Medicare PFFS, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Humana Group Medicare PFFS, you may get your care outside of Humana Group Medicare PFFS.

The insurance company that pays its share of your bills first is called the "**primary payer**." Then the other company or companies that are involved - called the "**secondary payers**" - each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second or at all depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many group members are covered by your group insurance.

If you have additional health insurance, please call Customer Service at the phone number shown in Section 1 to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov Web site.

For Bills: What do we pay? What does the Plan Pay?

In most instances, you should never pay the provider more than the cost sharing allowed by Humana Group Medicare PFFS. You should ask your provider to bill us for the rest of his or her fee and we will pay him or her according to Humana Group Medicare PFFS' terms and conditions of payment, which is the same as Original Medicare. If the provider does ask you to pay the remainder of the bill and have you directly reimbursed from the plan, then you will need to file a paper claim with us. Your membership card in Humana Group Medicare PFFS will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have him or her contact us.

If you receive a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. However, if you have already paid for the covered services we will reimburse you for our share of the cost.

Section 8 Your rights and responsibilities as a member of Humana Group Medicare PFFS

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a member of Humana Group Medicare PFFS, and we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS (see Section 1 for telephone number) and tell us you would like a decision if the service will be covered.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. must obey laws that protect you from discrimination or unfair treatment. These laws do not allow us to discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability. If you need help with communication, such as help from a language interpreter, please call Customer Service at the number shown in Section 1. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information when you enrolled in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call Customer Service at the phone number in Section 1.

Your right to see plan providers, get covered services, and get Part B prescription drugs filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from providers who have agreed to treat you under Humana Group Medicare PFFS' terms and conditions of payment. You have the right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and accepts Humana Group Medicare PFFS' terms and conditions of payment. You also have the right to timely access to your Part B prescriptions at any pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Humana Group Medicare PFFS. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone, such as a family member or friend, to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Section 1 of this booklet tells how to contact your SHIP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with the department that handles advance directives in your state (you can find contact information for the department in your state in the state specific data sheets at the end of the evidence of coverage).

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. The complaint is called an appeal or grievance depending on the situation. Appeals and grievances that involve your Medicare health benefits under Humana Group Medicare PFFS are discussed in Sections 9 and 10.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. You have the right under law to have a written / binding advance coverage determination made for the service. If you need more information, please call Customer Service at the number shown in Section 1. You have the right to an explanation from us about any bills you may get for services not covered by Humana Group Medicare PFFS. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 9 and 10 for more information about filing an appeal.

Your right to get information about Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc., Humana Group Medicare PFFS, plan providers, and your Part B drug coverage and costs

You have the right to find out from us how we pay our doctors. To get this information, call Customer Service at the phone number shown in Section 1. You have the right to get information from us about Humana Group Medicare PFFS. This includes information about our financial condition. To get any of this information, call Customer Service at the phone number listed on the cover.

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, call Humana Group Medicare PFFS (see Section 1) and tell us you would like a decision if the service will be covered.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Service at the number shown in Section 1. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called "Your Medicare Rights and Protections." To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the Web to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area (see the section at the back of the EOC for a list.)

- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Customer Service at the number shown in Section 1. You can also get help from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state).

What are your responsibilities as a member of Humana Group Medicare PFFS?

Along with the rights you have as a member of Humana Group Medicare PFFS, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Service at the phone number shown in Section 1 if you have any questions.

- When seeking care you must notify providers (unless it is an emergency) that you are enrolled in Humana Group Medicare PFFS, which is a Medicare private fee-for-service plan.

- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and to explain your treatment in a way you can understand.

- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.

- To pay your plan premiums and any co-payments you owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 7 of this booklet.

- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service at the phone number shown in Section 1.

Section 9 How to file a grievance

What is a Grievance?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal as described in Section 10 of this manual, because grievances do not involve problems related to coverage or payment for care or benefits, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending to soon.

For problems about coverage or payment for care, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending too soon, you must follow the rules outlined in Section 10.

What types of problems might lead to you filing a grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) Humana Group Medicare PFFS.
- Problems with the Customer Service you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 10.

Filing a grievance with Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc.

If you have a complaint, we encourage you to first call Customer Service at the number shown in Section 1. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this our Grievance process.

Grievance Process

Direct your written grievance to the following address:

Attn: Humana Grievance & Appeal Department
P.O. Box 14546
Lexington, KY 40512-4546

Note: You may also file a verbal grievance by calling 1-877-511-5000, TDD 1-800-833-3301.

When filing a grievance, please provide the following information:

- Your name, address, telephone number and member identification number; and
- A summary of the grievance, and any previous contact with us. Please include any notes or documents that may support your request.

We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

Who may file a grievance

You or your representative may file a grievance.

Expedited grievance process

You may request an expedited grievance if:

- You disagree with our decision to extend the timeframe to make an initial (standard) decision or reconsideration.
- We deny your request for a 72-hour/fast (expedited) initial decision.
- We deny your request for a 72-hour/fast (expedited) appeal.

You may make your request orally by calling 1-800-867-6601 (TDD 1-800-833-3301). You may fax your request to 1-800-949-2961. You may mail your request to Attn: Humana Grievance and Appeal Dept., Humana Group Medicare PFFS, P.O. Box 14546, Lexington, KY 40512-4546

Note: If you mail the request, we will provide oral acknowledgement upon receipt.

We will make a determination within 24 hours of receipt of your request.

For quality of care problems, you may also complain to the QIO

Complaints concerning the quality of care received under Medicare, including care during a hospital stay, may be acted upon by the plan sponsor under the grievance process, by an independent organization called the QIO, or by both. For any complaint filed with the QIO, the plan sponsor must cooperate with the QIO in resolving the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the introduction for more information about how to file a quality of care complaint with the QIO.

Section 10 Information on how to make a complaint about Part C medical services and benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from Humana Group Medicare PFFS or penalized in any way if you make a complaint.

Please refer to Original Medicare in Section 8 of your 2007 Medicare and You Handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a Medicare and You Handbook, please call 1-800 Medicare **(1-800-633-4227)** to get a copy.

How to make complaints in different situations

This section tells you how to complain about services or payment in each of the following situations:

Part 1. Complaints about what benefit or service we will provide you, or what we will pay for (cover).

Part 2. Complaints if you think you are being discharged from the hospital too soon.

Part 3. Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.

If you want to make a complaint about any type of problem other than those that are listed above, a **grievance** is the type of complaint you would make. **For more information about grievances, including how to file a grievance, see Section 9.**

PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE HUMANA INSURANCE COMPANY / HUMANA INSURANCE COMPANY OF NEW YORK / HUMANA INSURANCE OF PUERTO RICO, INC. OR HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC. WILL PROVIDE YOU OR WHAT HUMANA INSURANCE COMPANY / HUMANA INSURANCE COMPANY OF NEW YORK / HUMANA INSURANCE OF PUERTO RICO, INC. OR HUMANA HEALTH BENEFIT PLAN OF LOUISIANA, INC. WILL PAY FOR (COVER)

What are "complaints about your services or payment for your care?"

- If you are not getting the care you want, and you believe that this care is covered by Humana Group Medicare PFFS.

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.

- If you have received care that you believe should be covered by Humana Group Medicare PFFS, but we have refused to pay for this care because we say it is not covered.

If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS (See Section 1) and tell us you would like a decision.

What is an organization determination?

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received. If our initial decision is to deny your request, you can **appeal** the decision by going on to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of Humana Group Medicare PFFS apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Humana Group Medicare PFFS, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by Humana Group Medicare PFFS).

Who may ask for an "initial decision" about your medical care or payment?

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. The person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is sometimes called an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the following address: Humana Group Medicare PFFS, P.O. Box 14601, Lexington, KY 40512-4601.

Asking for a fast decision

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at 1-866-737-5113 (TTY 1-800-877-8973). Or, you can deliver a written request to Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc., Humana Correspondence, P.O. Box 14601, Lexington, KY 40512-4601, or fax it to 1-888-200-7440. After normal business hours, holidays and weekends, please fax your request or call the number and leave a detailed message. Be sure to ask for a "fast" or "72-hour" review.

If any doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 9.

What happens next when you request an initial decision?

1. For a decision about payment for care you already received.

We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the timeframe for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can appeal this decision. (An appeal is also called a "reconsideration.")

2. For a standard initial decision about medical care.

We have 14 days to make a decision after we have received your request. However, we can take up to 14 more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance" (see Section 9).

If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision.

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

3. For a fast initial decision about medical care.

If you receive a "fast" decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it - sooner if your health requires. However, we can take up to 14 more days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any additional days, you can file a fast grievance.

We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for coverage or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration."

Please call us at 1-800-867-6601 if you need help in filing your appeal. We give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" appeal are the same as those described for a "standard" or "fast" initial decision. While the process for deciding on a standard or fast appeal is the same as a standard or fast determination, the place where the appeal is sent is different. See "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Humana Grievance and Appeal Department, Attn: Humana Grievance and Appeal Department, Humana Group Medicare PFFS, P.O. Box 14546, Lexington, KY 40512-4546.
- By fax, at 1-800-949-2961.
- By telephone - if it is a "fast appeal" - at 1-800-867-6601 (TDD 1-800-833-3301).
- In person, at 101 East Main Street, Louisville, KY 40202.

You also have the right to ask us for a copy of information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.

How do you file your appeal of the initial decision?

The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the instructions under "Who may ask for an 'initial decision' about medical care or payment?" However, providers with Humana Group Medicare PFFS must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, until after the appeal is resolved.

How soon must you file your appeal?

You need to file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal you can call us at the telephone number shown in Section 1, or send the appeal to us in writing at Humana Group Medicare PFFS, P.O. Box 14546, Lexington, KY, 40512-4546.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" initial decision. While the process for deciding on a standard or fast appeal is the same as the process for standard or fast determinations, the place where the appeal is sent is different. Mail your request to Humana Group Medicare PFFS, P.O. Box 14546, Lexington, KY, 40512-4546.

How soon must we decide on your appeal?

1. For a decision about payment for care you have already received.

After we receive your appeal, we have 60 days to make a decision. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

2. For a standard decision about medical care.

After we receive your appeal, we have up to 30 days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. For a fast decision about medical care.

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens next if we decide completely in your favor?

1. For a decision about payment for care you already received.

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision.

2. For a standard decision about medical care.

We must authorize or provide you with the care you have asked for no later than 30 days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

3. For a fast decision about medical care.

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal - or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal, your appeal automatically goes on to Appeal Level 2, where an independent review organization will review your case. This organization contracts with the federal government and is not part of Humana Group Medicare PFFS. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the organization depends on the type of appeal:

1. **For a decision about payment for care you have already received.**

   We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

2. **For a standard decision about medical care.**

   We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. **For a fast decision about medical care.**

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Appeal Level 2: If we deny any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization

At the second level of appeal, your case is given a new review by an outside, independent review organization that has a contract with CMS (**C**enters for **M**edicare & Medicaid **S**ervices), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we send to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

1. For an appeal about payment for care, the independent review organization has up to 60 days to make a decision.

2. For a standard appeal about medical care, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

3. For a fast appeal about medical care, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

1. For an appeal about payment for care.

We must pay within 30 days after receiving the decision.

2. For a standard appeal about medical care.

We must authorize the care you have asked for within 72 hours after receiving notice of the decision, or provide the care no later than 14 days after receiving the decision.

3. For a fast appeal about medical care.

We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. may request a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement, the Council's decision is final.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we may ask a Federal Court Judge to review the case.

How soon will the judge make a decision?

The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

PART 2. COMPLAINTS (APPEALS) IF YOU THINK YOU ARE BEING DISCHARGED FROM THE HOSPITAL TOO SOON

When you are hospitalized, you have the right to get all the hospital care covered by Humana Group Medicare PFFS that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

When you are admitted to the hospital, someone at the hospital should give you a notice called the Important Message from Medicare. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.

- That your doctor or the hospital may arrange for services you will need after you leave the hospital.

- Your right to appeal a discharge decision.

Review of your hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, ask us to give you a notice called the Notice of Discharge & Medicare Appeal Rights. This notice will tell you:

- Why you are being discharged.

- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).

- What you can do if you think you are being discharged too soon.

- Who to contact for help.

You (or your representative) may be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital - it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the Notice of Discharge & Medicare Appeal Rights, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Humana Group Medicare PFFS or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must quickly contact the QIO. The Notice of Discharge & Medicare Appeal Rights gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called an "immediate review."

- You must be sure that you have made your request to the QIO no later than noon on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, we will continue to cover your hospital stay for as long as it is medically necessary.

What happens if the QIO denies your request?

If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Humana Group Medicare PFFS for a "fast appeal" of your discharge

If you do not ask the QIO for a fast review of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary.

- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date (unless the independent review organization overturns our decision).

PART 3. Complaints (appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon

When you are a patient in a SNF, **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by Humana Group Medicare PFFS that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA, or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or your representative) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end - it only means that you received the notice.

How to get a review of your coverage by the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the **Q**uality **I**mprovement **O**rganization (the "QIO") to do an independent review of whether it is medically appropriate to terminate your coverage.

How soon do you have to ask the QIO to review your coverage?

If you want to appeal the termination of your coverage, you must quickly contact the QIO. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must make your request **no later than noon** of the day after you get the notice.

- If you get the notice and you have more than 2 days before your coverage ends, you must make your request **no later than noon** of the day before the date that your coverage ends.

What will happen during the review?

The QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why we believe that your services should end.

After reviewing all the information, the QIO will decide whether it is medically appropriate to terminate your coverage on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA, or CORF services for as long as medically necessary.

What happens if the QIO denies your request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA, or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Humana Group Medicare PFFS will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Humana Group Medicare PFFS for a "fast appeal" of your discharge.

If you do not ask the QIO for a fast appeal of your coverage termination by the deadline, you can ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, we will continue to cover your care for as long as medically necessary.

- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.

Section 11 Leaving Humana Group Medicare PFFS and your choices for continuing Medicare after you leave

What is "disenrollment"?

"Disenrollment" from Humana Group Medicare PFFS means **ending your membership** in Humana Group Medicare PFFS. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Humana Group Medicare PFFS because you have decided that you want to leave. You can do this for any reason.

- There are also a few situations where you would be required to leave. For example, you would have to leave Humana Group Medicare PFFS if you move out of our geographic service area or if Humana Group Medicare PFFS leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you should keep getting your Medicare services through Humana Group Medicare PFFS or you will have to pay more for your services.

If you leave Humana Group Medicare PFFS, it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and **should** continue to get your care as usual through Humana Group Medicare PFFS.

What should I do if I decide to leave Humana Group Medicare PFFS?

If you want to leave Humana Group Medicare PFFS:

- The first step is **to be sure that the type of change you want to make and when you want to make it fit with the new rules** explained below about changing how you get Medicare. If the change does not fit with these rules, you won't be allowed to make the change.

- Then, what you must do to leave Humana Group Medicare PFFS depends on whether you want to switch to Original Medicare or to one of your other choices.

When and how often can I change my Medicare choices?

In general, there are only certain times during the year when you can change the way you get Medicare.

Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Contact us for information.

What are my choices, and how do I make changes, if I leave Humana Group Medicare PFFS?

If you leave Humana Group Medicare PFFS, you have a number of choices for how you receive your Medicare after you leave, but please contact your Group Benefits Administrator (Kentucky Teachers' Retirement System) first as this may effect your ability to reenroll through Kentucky Teachers' Retirement System. Additional plans are available outside of Kentucky Teachers' Retirement System, if they are available in your area, and if they are accepting new members, you can switch to any of the following types of plans:

- **Other Medicare Advantage Plans** (including Private Fee-For-Service plans such as Humana Group Medicare PFFS, HMOs, and PPOs) are available in some parts of the country. In HMOs and PPOs, you generally get all your Medicare-covered Part A and Part B health care through the plan. Medicare Advantage Plans may include prescription drug coverage as part of the Medicare Prescription Drug (Part D) benefit. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. Humana Group Medicare PFFS is a Medicare Advantage Plan offered by Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc.

- **Original Medicare** is available throughout the country. Original Medicare is a fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare-approved amount and you pay your share (coinsurance). Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

- **Medicare Prescription Drug Plans** (PDPs) are stand-alone drug plans that only cover prescription drugs, not other benefits or services. If you choose Original Medicare and want to receive Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.

- **Other Medicare Health Plans** (including Medicare Cost Plans, Programs of All-Inclusive Care for the Elderly (PACE), and Demonstrations) may be available. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage may include prescription drug coverage.

If you leave Kentucky Teachers' Retirement System, you cannot return except during open enrollment or if you have a qualifying event. If you sign up for a prescription drug plan you are no longer eligible for a Kentucky Teachers' Retirement System plan.

Note: For more information about your choices, please refer to the "Medicare & You" handbook you received in the fall. You may also call 1-800-MEDICARE (1-800-633-4227) or visit **www.medicare.gov** to learn more about your choices.

Please be advised: You may not be able to resume group coverage if you choose to disenroll. Contact your Group Benefit Administrator (Kentucky Teachers' Retirement System) before you disenroll.

How do I switch from Humana Group Medicare PFFS to another Medicare Advantage Plan or Other Medicare Health Plan

If you want to change from Humana Group Medicare PFFS to a different Medicare Advantage Plan or Other Medicare Health Plan, here is what to do:

1. Contact the new plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit.

2. Your new plan will tell you the date when your membership in that plan begins, and your membership in Humana Group Medicare PFFS will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and must continue to get your medical care as usual through Humana Group Medicare PFFS until the date your membership ends.

Please be advised: You may not be able to resume group coverage if you choose to disenroll. Contact your Group Benefit Administrator (Kentucky Teachers' Retirement System) before you disenroll.

What if I want to switch (disenroll) from Humana Group Medicare PFFS to Original Medicare?

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from Humana Group Medicare PFFS to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan, if you do not already have coverage through another creditable plan.

To get information about Prescription Drug Plans that you can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

- If you want Original Medicare and Medicare prescription drug coverage, simply enroll in a stand-alone Medicare Prescription Drug Plan (PDP).

- If you want Original Medicare and do not want Medicare prescription drug coverage, simply tell us or Medicare that you want to leave Humana Group Medicare PFFS. You do not have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave Humana Group Medicare PFFS.

- To tell us that you want to leave Humana Group Medicare PFFS:

  - You can write a letter to us or your Group Benefits Administrator (Kentucky Teachers' Retirement System) and send it to Customer Service (see Section 1). Be sure to sign and date your letter.

  - **To tell Medicare** you want to leave Humana Group Medicare PFFS, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Whether you tell us, your Group Benefits Administrator (Kentucky Teachers' Retirement System) or Medicare that you want to leave Humana Group Medicare PFFS, you will receive a letter telling you when your membership will end. This is your **disenrollment date** - the day you officially leave Humana Group Medicare PFFS. Remember, until your disenrollment date, you are still a member of Humana Group Medicare PFFS and must continue to get your medical care as usual through Humana Group Medicare PFFS.

When your membership in Humana Group Medicare PFFS ends, you should use your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will automatically be in Original Medicare when you leave Humana Group Medicare PFFS. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

What are my choices, and how do I make changes, if I leave Humana Group Medicare PFFS?

Please consult your Group Benefits Administrator (Kentucky Teachers' Retirement System) before disenrolling.

Do I need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Humana Group Medicare PFFS to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact the SHIP in your state (the phone number is in Section 1). You can ask the SHIP about how and when to buy a Medigap policy if you need one. The SHIP can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, and you do not have a guaranteed issue right, the Medigap insurer can refuse to sell you a policy, or impose limits based on your health. If you have a "**guaranteed issue right**," this means that for a limited period the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare, in certain situations you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period. You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join Humana Group Medicare PFFS or another Medicare health plan for the first time; or (2) joined Humana Group Medicare PFFS or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. The SHIP can tell you about other situations where you may have guaranteed issue rights. You may also have a guaranteed issue right if you move out of our service area, or if we stop providing Medicare benefits.

If you do want to buy a Medigap policy, you have to follow the instructions below for changing from Humana Group Medicare PFFS to Original Medicare. (Buying a Medigap policy does not switch you from Humana Group Medicare PFFS to Original Medicare. In fact, while you are still enrolled in Humana Group Medicare PFFS it is against the law for a Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your Humana Group Medicare PFFS membership and put you in Original Medicare.)

What happens to you if Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. leaves the Medicare program, or Humana Group Medicare PFFS leaves the area where I live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Humana Group Medicare PFFS will end and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Humana Group Medicare PFFS until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. plan, another Medicare Advantage Plan, or a Private Fee-For-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from Humana Group Medicare PFFS to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

Under certain conditions Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. can end your membership and make you leave the plan.

We cannot **ask you to leave the plan because of your health.**

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Humana Group Medicare PFFS because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We can **ask you to leave the plan under certain special conditions.**

If any of the following situations occur, we will end your membership in Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc.

- If you do not stay continuously enrolled in both Medicare Part A and Medicare Part B.

- If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in Humana Group Medicare PFFS.

- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of Humana Group Medicare PFFS. We cannot make you leave Humana Group Medicare PFFS for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.

- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

- If you do not pay the plan premiums, your Group Benefits Administrator (Kentucky Teachers' Retirement System) or we will tell you in writing that you have a 90-day grace period during which you can pay the plan premiums before you are required to leave Humana Group Medicare PFFS.

You have the right to make a complaint if we ask you to leave Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc.

If we ask you to leave Humana Group Medicare PFFS, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

Section 12 Legal notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the **C**enters for **M**edicare & Medicaid **S**ervices, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the States of Alabama, Alaska, Arkansas, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, West Virginia, Wisconsin and Wyoming may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc., must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Section 13 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term.

Advanced imaging services - Means Computed Tomography Imaging (CT/CAT) Scan, Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), and Positron Emission Tomography (PET) Scan.

Ambulatory surgical center - Is a freestanding facility that provides medical surgical procedures on an outpatient basis for the prevention, diagnosis and treatment of an injury or illness. This facility is staffed by physicians and provides treatment by, or under the supervision of, physicians as well as nursing care. This type of facility does not provide inpatient room and board and is Medicare certified and licensed by the proper authority.

Annual out-of-pocket maximum - Means a limit on the out-of-pocket expenses that you pay during a plan year. The maximum out-of-pocket limit consists of the amount you pay to satisfy the copayment/coinsurance requirements for covered services. If you reach this maximum, no further out-of-pocket will be required of you for covered expenses during the year. Expenses for outpatient prescription drugs, outpatient surgery copays, and non-emergency care while in a foreign country do not apply toward this maximum.

Appeal - A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 9 and 10 explain about appeals, including the process involved in making an appeal.

Benefit period - For both Humana Group Medicare PFFS and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 6 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital. (The type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital.)

CMS - Stands for the **C**enters for **M**edicare & Medicaid **S**ervices, the agency within the Department of Health and Human Services responsible for the administration of the Medicare program, as well as the federal participation in the state Medicaid program.

Clinical trial - Means a way of testing new types of medical care, such as new cancer drugs. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Coinsurance - Is the percentage of the Medicare allowable charge for each service that you have to pay. This fee is payable to the provider.

Complaint - Is a verbal expression of dissatisfaction with any aspect of the plan.

Comprehensive Outpatient Rehabilitation Facility (CORF) - Means a facility that provides a variety of services including physicians' services, physical therapy, social or psychological services, and outpatient rehabilitation.

Copayment - Is the fixed amount you are responsible for paying at the time the service is provided. This fee is payable to the provider.

Covered services - The general term we use in this booklet to mean all of the health care services and supplies that are covered by Humana Group Medicare PFFS. Covered services are listed in the Benefits Chart in Section 4.

Custodial care - Means non-medical care, including room and board, provided to a person with a mental or physical condition who requires help in daily living or meeting his or her own personal needs. Custodial care can be provided by persons without professional skills or training who can provide assistance with mobility, dressing, bathing, eating, preparation of special diets and taking medication. Custodial care is not covered by Humana Group Medicare PFFS.

Customer Service - A department within Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Customer Service.

Deemed provider - A provider is a deemed provider and must follow a PFFS plan's terms and conditions of payment if the following conditions are met: a) in advance of furnishing services the provider knows that a patient is enrolled in a PFFS plan; and b) the provider either possesses or has access to the plan's terms and conditions of payment.

It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan. However, when a provider chooses to furnish services to a PFFS enrollee and the deeming conditions have been met, the provider is automatically a deemed provider (for that enrollee) and must follow the PFFS plan's terms and conditions of payment.

Disenroll or disenrollment - The process of ending your membership in Humana Group Medicare PFFS. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about disenrollment.

Durable medical equipment - Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Effective date - Is the actual day, month and year your coverage becomes effective in Humana Group Medicare PFFS, or the date your disenrollment from Humana Group Medicare PFFS becomes effective. We confirm your effective date with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS). You will also receive written notification from us of your effective date.

Emergency care - Covered services that are: 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Emergency medical conditions - Are medical conditions which have severe symptoms (including severe pain). The severity of these symptoms would lead a person with average knowledge of health and medicine (prudent layperson) to reasonably expect that if immediate medical attention were not received, the result could be:

- Serious jeopardy to your health (if you are pregnant, the health of your unborn child);
- Serious damage or impairment to the functioning of your body; or
- Serious dysfunction of any organ or part of your body.

Examples of emergency medical conditions include conditions such as chest pain, difficulty breathing, severe burns, penetrating wounds or vomiting blood.

End-stage renal disease - Is permanent kidney failure which requires regular kidney dialysis or a transplant to maintain life.

Evidence of coverage and disclosure information - This document along with your enrollment, which explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of the Humana Group Medicare PFFS.

Exclusions/limitations - Are items or services which are limited or not covered by Humana Group Medicare PFFS.

Expedited appeal - Means a verbal or written request from you or your authorized representative asking us to reconsider a service denial, termination of care or a reduction in the level of care within 72 hours because your life, health or ability to regain maximum function could be seriously jeopardized.

Experimental or investigational procedures and items - As determined by Medicare, are procedures and items not generally accepted by the medical community. When making a determination as to whether a service is experimental/investigational, we will use Medicare guidelines or rely upon determinations already made by Medicare. Experimental/investigational procedures are not covered by Humana Group Medicare PFFS.

Grievance - A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 9 for more information about grievances.

Group Benefits Administrator - Kentucky Teachers' Retirement System, 479 Versailles Road, Frankfort, KY 40601 (502) 848-8500 or 800-618-1687.

Home health agency - Is a state-licensed and Medicare-certified agency which provides part-time intermittent skilled nursing care and other therapeutic services in your home.

Homemaker services - Means general household services such as laundry, meal preparation, shopping or other home care services furnished mainly to assist people in meeting personal, family or domestic needs. Homemaker services are not covered by Humana Group Medicare PFFS.

Hospice - Is a Medicare-certified organization or agency that primarily engages in providing pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital - Is an institution which provides inpatient, outpatient, emergency, diagnostic and therapeutic services, and participates in and is eligible for payments under the Medicare program. The term "hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in the routines of daily living.

Hospital services - Means any care received in a hospital on an inpatient or outpatient basis, including emergency services or urgently needed care.

Illness - Means a disturbance in the function or structure of your body which causes physical signs or symptoms and which if left untreated, will result in the deterioration of the health state, structure or system of your body.

Immediate care facility - Is a facility established to diagnose and treat an unforeseen injury or illness on an outpatient basis. This facility is staffed by physicians and provides treatment by, or under, the supervision of physicians as well as nursing care. This type of facility does not provide inpatient room and board.

Injury - Means bodily damage including all related conditions and recurrent symptoms.

Inpatient care - Health care that you get when you are admitted to a hospital.

Intermittent skilled nursing and home health care - Means either:

- Ongoing part-time medically necessary care received on a non-daily basis for up to 35 hours per week; or
- Full-time medically necessary care received on a temporary basis for a period of up to 21 days, or under certain circumstances longer if the extension is for a finite and predictable number of days.

Mammography Screening - Means a radiological procedure for early detection of breast cancer, and includes a physician's interpretation of the results.

Medical facility - Is a Medicare-certified hospital, surgical facility, substance abuse treatment facility, skilled nursing facility, home health agency, mental health facility or hospice as defined in this section. It must be licensed, registered or approved by the appropriate authority.

Medically necessary - Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medical necessity is determined by Medicare.

Medical social services - Means services such as post-hospital discharge planning and counseling to help you or your family adjust to an illness.

Medical supplies - Are disposable supplies used by a health care professional in the treatment of an illness or injury. Medical supplies include surgical dressings, splints and casts.

Medicare - The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization - A public or private organization licensed by the state as a risk-bearing entity that is under contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Humana Insurance Company / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. or Humana Health Benefit Plan of Louisiana, Inc. is a Medicare Advantage Organization.

Medicare Advantage Plan - A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. Humana Group Medicare PFFS is a Medicare Advantage Plan.

Medicare Cost Plan - Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under Section 1876(h) of the Act.

Medicare Managed Care Plan - Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Part A - Refers to Original Medicare and means the part of Medicare that would cover the cost of inpatient care (following the payment of a deductible) in a Medicare-certified hospital, or in a Medicare-certified skilled nursing facility following a hospital stay. It may also cover hospice and home health care. Most nursing homes are not skilled nursing facilities and, therefore, are not covered by Medicare.

Medicare Part B - Refers to Original Medicare and means the part of Medicare that reimburses for physician services, outpatient hospital care and some other services not covered by Part A. Again, a deductible must first be paid by the Medicare recipient.

Medicare beneficiaries are required to pay a monthly premium to Medicare for Part B coverage. For Medicare beneficiaries that receive a Social Security annuity check, this premium is usually automatically deducted from their check. Otherwise, the premium is paid directly by the Medicare beneficiary or someone on their behalf (such as their State Medicaid agency). NOTE: Humana Group Medicare PFFS members must continue to pay their Medicare Part B premium.

"Medigap" (Medicare supplement insurance) policy - Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (Member of Humana Group Medicare PFFS, or "plan member") - A person with Medicare who is eligible to get covered services, who has enrolled in Humana Group Medicare PFFS, and whose enrollment has been confirmed by the **C**enters for **M**edicare & Medicaid **S**ervices (CMS).

Office visit - Means any visit for covered services to the office of a provider.

Organization determination - The MA organization has made an organization determination when it makes a decision about MA services or payment that you believe you should receive.

Original Medicare - Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Part-time skilled nursing and home health care - Means less than eight hours per day for up to 35 hours per week of skilled nursing and home health care services that are medically necessary.

Partial hospitalization - Means an ambulatory program of active care for mental health services that last less than 24 hours a day. Services may be furnished by hospital outpatient units or by qualified community mental health centers.

Physician - Means a person legally licensed to practice medicine or surgery.

Plan service area - Is the geographic area where a person must live in order to be eligible for the benefits and rates approved by CMS for that area, and to be able to become or remain a member of Humana Group Medicare PFFS.

Plan provider - "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "plan providers" when they "accept" Humana Group Medicare PFFS. When we say that plan providers "accept Humana Group Medicare PFFS," this means that we have arranged with them to coordinate or provide covered services to members of Humana Group Medicare PFFS.

Plan year - Is the 12 month period that entitles you to the covered services outlined in the plan's Evidence of Coverage.

Preventive services - Are services determined to be effective and accepted for the prevention of disease in persons with no symptoms.

Primary Care Physician (PCP) - A health care professional who is trained to give you basic care, including physicians practicing in the following areas: Family Practice, Internal Medicine, General Medicine, OB/GYN, and Pediatrics. You can receive care from any doctor, specialist or hospital in the U.S. who is eligible to be paid by Medicare and accepts Humana Group Medicare PFFS' terms and conditions of payment. Humana Group Medicare PFFS covers you for all Medicare A and B services and the supplemental benefits described in this document. Section 3 tells more about PCPs.

Private Fee-for-Service Plan - A Medicare Advantage Private Fee-For-Service plan is a Medicare Advantage plan that pays providers of services at a rate determined by Medicare on a fee-for-service basis, without placing the provider at financial risk. A Medicare Advantage Organization wishing to offer a PFFS plan must meet general requirements for Medicare Advantage Organizations required by law, including:

- Providing for all original Medicare covered services;
- Providing for emergency and urgent care;
- Allowing beneficiary appeals for services that are limited, not provided, not paid for, or not allowed; and
- Disclosing its terms and conditions of payment and a list of services it provides.

A Medicare Advantage Organization offering a PFFS plan:

- Does not vary the rates for a provider based on the utilization of that provider's services;
- Does not restrict enrollees' choices among providers that: (a) agree to accept the plan's terms and conditions of payment, and (b) are lawfully authorized to provide services; and
- Does not limit enrollees to a provider network (no "lock in").

Special access rules apply to PFFS plans.

Members of a PFFS plan may go to any doctor or hospital in the U.S. that is:

- Eligible to be paid by Medicare (that is: (a) the provider is state licensed; (b) is eligible to receive, or has received, a Medicare billing number; and (c) for Institutional providers, such as hospitals and skilled nursing facilities, is certified to treat Medicare beneficiaries); and
- Is willing to accept the plan's terms of payment.

PFFS plans may offer supplemental benefits.

Prosthetic devices - Means devices needed to substitute for a missing body part.

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans, and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 9 and Section 10 for information about making complaints to the QIO.

Referral - You do not need a referral to obtain care in a Private Fee-For-Service plan. If you have any questions about whether Humana Group Medicare PFFS will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Humana Group Medicare PFFS (see Section 1) and tell us you would like a decision if the service will be covered.

Rehabilitation services - These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 6 for more information.

Service area - Section 2 tells about Humana Group Medicare PFFS's service area. "Service area" is the geographic area approved by the **C**enters for **M**edicare & Medicaid **S**ervices (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Skilled nursing care - Means services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled nursing facility (SNF) - Is a facility which provides inpatient skilled nursing care, rehabilitation services or other related health services and is certified by Medicare. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Specialist - Is a licensed physician, psychologist or other practitioner not identified as a primary care physician, that you go to for specialized care.

Terms and conditions of participation (payment) - The PFFS terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan. At a minimum the terms and conditions will specify:

- A list of all services that the plan provides;
- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures;
- The amount the provider is permitted to collect from the enrollee, including balance billing; and
- The PFFS plan is not required to reimburse providers for services to PFFS plan enrollees, if these services are not covered by the plan.

A Private Fee-For-Service organization is required to make its terms and conditions of participation reasonably available - through phone, fax, email, or websites - to providers in the U.S. from whom its enrollees seek health care services.

Urgently needed care - Section 3 explains about urgently needed services. These are different from emergency services.

We, our and **us** - Means Humana Group Medicare PFFS.

You and **your** - Means the person covered by Humana Group Medicare PFFS.

Section 14 Ship Name and Contact Information

State	**Alabama**
SHIP Name and Contact Information	Alabama Department of Senior Services P.O. Box 301851 770 Washington Avenue, Suite 470 Montgomery, AL 36130 Phone: 1-800-243-5463 (toll-free)/ 1-334-242-5743 (local) TTY: 1-334-242-0995
Quality Improvement Organization	Alabama Quality Assurance Foundation 2 Perimeter Park South, Suite 200 West Birmingham, AL 35243 Phone: 1-800-760-3540 (toll-free)/ 1-205-970-1600 (local)
State Agency dealing with Advance Directives	Alabama Department of Public Health 201 Monroe Street, RSA Tower Montgomery, AL 36104 (334) 206-5300
State Medicaid Office	Medicaid Agency of Alabama P.O. Box 5624 501 Dexter Ave. Montgomery, AL 36103-5624 Phone: 1-800-362-1504 (toll-free)/ 1-334-242-5000 (local)

State	**Alaska**
SHIP Name and Contact Information	Alaska SeniorCare/Medicare Information and Referral Office 3601 C St., Suite 310 Anchorage, AK 99503 800-478-6065 (in state calls only)/ 907-269-3680 (local) TTY: 1-907-269-3691
Quality Improvement Organization	QualisHealth 721Sesame Street, Suite 1A Anchorage, AK 99503 1-800-878-7170 (toll-free)/ 907-562-2252 (local)
State Agency dealing with Advance Directives	907-465-3744
State Medicaid Office	Alaska Department of Health and Social Services 350 Main Street, Room 229 P.O. Box 110601 Juneau, AK 99811-0601 1-800-780-9972 (toll free)/907-465-3355 (local)

State	**Arizona**
SHIP Name and Contact Information	Arizona State Health Insurance Assistance Program 1789 West Jefferson Street, #950A Phoenix, AZ 85007 Phone: 1-800-432-4040 (toll-free) TTY: 1-602-542-6366
Quality Improvement Organization	Health Services Advisory Group, Inc. 1600 East Northern Avenue, Suite 100 Phoenix, AZ 85020-3933 Phone: 1-800-359-9909 (toll free)/ 602-264-6382 (local)
State Agency dealing with Advance Directives	Arizona Department of Health Services 150 North 18th Avenue, Suite 450 Phoenix, AZ 85007 (602) 542-1000
State Medicaid Office	Health Care Cost Containment of Arizona 801 East Jefferson Phoenix, AZ 85034 Phone: 1-800-523-0231 (toll-free)/ 1-602-417-7700 (Spanish) TTY: 602-417-4191

State	**Arkansas**
SHIP Name and Contact Information	State Health Insurance Assistance Program of Arkansas 1200 West Third Street Little Rock, AR 72201-1904 Phone: 800-224-6330 (toll free)/ 501-371-2782 (local)
Quality Improvement Organization	Arkansas Foundation for Medical Care 2201 Brooken Hill Drive Fort Smith, AR 72908 Phone: 1-800-272-5528 (toll free)/ 1-479-649-8501 (local)
State Agency dealing with Advance Directives	Division of Aging and Adult Services P.O. Box 1437, Slot S530 Little Rock, AR 72203-1437 (501) 682-2441
State Medicaid Office	Department of Human Services of Arkansas Donahey Plaza South P.O. Box 1437, Slot 1100 Little Rock, AR 72203-1437 Phone: 1-800-482-5431 (toll free)/ 501-682-8233 (local)/1-800-482-8988 (Spanish) TTY: 1-501-682-6789

State	**California**
SHIP Name and Contact Information	Health Insurance Counseling and Advocacy Program (HICAP) of California 1600 K Street Sacramento, CA 95814 Phone: 800-434-0222 (In-State Calls)
Quality Improvement Organization	Lumetra One Sansome Street, Suite 600 San Francisco, CA 94104 Phone: 1-800-841-1602 (toll free)/ 1-415-677-2000 (local)
State Agency dealing with Advance Directives	1-800-952-5225
State Medicaid Office	California Department of Health Services P.O. Box 997413 Sacramento, CA 95899-7413 Phone: 1-916-636-1980 (local)

State	**Colorado**
SHIP Name and Contact Information	Colorado State Health Insurance Assistance Program 1560 Broadway, Suite 850 Denver, CO 80202 Phone: 1-888-696-7213 (toll free)/ 1-303-894-7552 (local)/ 1-866-665-9668 (Spanish) TTY: 1-303-894-7880
Quality Improvement Organization	Colorado Foundation for Medical Care 2851 South Parker Road, Suite 1000 Aurora, CO 80014 Phone: 1-800-950-8250 (toll-free)/ 1-303-695-3300 (local) TTY: 1-303-695-3314
State Agency dealing with Advance Directives	Colorado Department of Public Health and Environment 4300 Cherry Creek Dr. South Denver, CO 80246-1530 (303) 692-2000
State Medicaid Office	Department of Health Care Policy and Financing of Colorado 1570 Grant Street Denver, CO 80203-1818 Phone: 1-800-221-3943 (toll-free)/ 1-303-866-2993 (local)/ 1-303-866-1416 (Spanish) TTY: 1-303-866-3883

State	**Connecticut**
SHIP Name and Contact Information	CHOICES 25 Sigourney Street, 10th Floor Hartford, CT 06106 Phone: 1-800-994-9422 (toll-free: in-state calls only)/1-860-424-5862 (local) TTY: 1-860-842-5424
Quality Improvement Organization	Qualidigm 100 Roscommon Drive, Suite 200 Middletown, CT 06457 Phone: 1/800-553-7590 (toll-free)/ 1-860-632-2008 (local)
State Agency dealing with Advance Directives	1-860-808-5318
State Medicaid Office	Department of Social Services of Connecticut 25 Sigourney Street Hartford, CT 06106-5033 Phone: 800-842-1508 (toll free: in-state calls only)/1-860-424-4908 (local)
State	**Delaware**
SHIP Name and Contact Information	ELDERinfo 841 Silverlake Blvd. Dover, DE 19904 Phone: 1-/800-336-9500 (toll-free: in-state calls only)/1-302-739-6266 (local)
Quality Improvement Organization	Quality Insights of Delaware Plaza III 1847 Marsh Road Wilmington, DE 19810 Phone: 1-302-478-3600 (local)
State Agency dealing with Advance Directives	302-577-8338
State Medicaid Office	Delaware Health and Social Services 1901 N. DuPont Highway P.O. Box 906, Lewis Building New Castle, DE 19720 Phone: 1-800-372-2022 (toll-free)/ 1-302-255-9500 (local)

State	**Florida**
SHIP Name and Contact Information	SHINE 4040 Esplanade Way, Building B, Suite 260 Tallahassee, FL 32399 Phone: 1-800-963-5337 (toll-free)/ 1-850-414-2060 (local) TTY: 1-850-414-2001
Quality Improvement Organization	Florida Medical Quality Assurance 4350 West Cypress Street, Suite 900 Tampa, FL 33607 Phone: 1-800-844-0795 (toll-free)/ 1-813-354-9111 (local)
State Agency dealing with Advance Directives	Medical Quality Assurance 4052 Bald Cypress Way, Bin #C00 Tallahassee, FL 32399-3250 (850) 245-4224
State Medicaid Office	Agency for Health Care Administration of Florida P.O. Box 13000 Tallahassee, FL 32317-3000 Phone: 1-866-762-2237 (toll free: in-state calls only)/1-850-488-3560 (local)
State	**Georgia**
SHIP Name and Contact Information	GeorgiaCares 2 Peachtree Street, NW, Suite 9-230 Atlanta, GA 30303 Phone: 1-/800-669-8387 (toll-free)/ 1-404-657-5334 (local)
Quality Improvement Organization	Georgia Medical Care Foundation 1455 Lincoln Parkway, Suite 800 Atlanta, GA 30346 Phone: 1-800-979-7217 (toll-free)/ 1-404-982-0411 (local)
State Agency dealing with Advance Directives	Office of Regulatory Services Georgia Department of Human Resources 2 Peachtree Street, NW 21st Floor, Ste 21-325 Atlanta, GA 30303
State Medicaid Office	Georgia Department of Community Health 2 Peachtree Street, NW Atlanta, GA 30303 Phone: 1-866-322-4260 (toll-free)/ 1-770-570-3300 (local)

State	**Hawaii**
SHIP Name and Contact Information	PLUS 250 South Hotel Street Suite 406 Honolulu, HI 96813 Phone: 1-888-875-9229 (toll-free)/ 1-808-586-7299 (local)
Quality Improvement Organization	Mountain Pacific Quality Health Foundation 1360 S. Beretania Street, Suite 501 Honolulu, HI 96814 Phone: 1-800-524-6550 (toll-free)/ 1-808-545-2550 (local)
State Agency dealing with Advance Directives	808-586-1500
State Medicaid Office	Department of Human Services of Hawaii P.O. Box 339 Honolulu, HI 96809 Phone: 1-808-587-3521 (local) TTY: 1-808-692-7182
State	**Idaho**
SHIP Name and Contact Information	Senior Health Insurance Benefit Advisors of Idaho (SHIBA) 700 West State Street, 3rd Floor Boise, ID 83720-0043 Phone: 1-800-247-4422 (toll-free/in-state calls only)
Quality Improvement Organization	QualisHealth 720 Park Blvd., Suite 120 Boise, ID 83712 Phone: 1-800-488-1118 (toll-free)/ 1-208-343-4617 (local)
State Agency dealing with Advance Directives	Idaho Department of Health and Welfare 450 West State Street Boise, ID 83720-0036 (208) 334-5500
State Medicaid Office	Idaho Department of Health and Welfare 3232 Elder Boise, ID 83705-4711 Phone: 1-877-200-5441 (toll-free)/ 1-208-334-5747 (local) TTY: 1-208-332-7205

State	**Illinois**
SHIP Name and Contact Information	Senior Health Insurance Program of Illinois (SHIP) 320 West Washington Street Springfield, IL 62767 Phone: 1-800-548-9034 (toll-free: in-state calls only)/1-217-785-9021 (local) TTY: 1-217-524-4872
Quality Improvement Organization	Illinois Foundation for Quality Health Care 2625 Butterfield Road, Suite 104S Oakbrook, IL 60523 Phone: 1-800-386-6431 (toll-free)/ 1-630-571-5540 (local)
State Agency dealing with Advance Directives	Illinois Department of Public Health 535 W. Jefferson Street Springfield, IL 62761 (217) 782-4977
State Medicaid Office	Illinois Department of Healthcare and Family Services 201 South Grand Avenue, East Springfield, IL 62763 Phone: 1-866-468-7543 (toll-free)/ 1-217-782-1200 (local)/ 1-217-785-8036 (Spanish)

State	**Indiana**
SHIP Name and Contact Information	Indiana Senior Health Insurance Information Program (SHIP) 311 West Washington Street, Suite 300 Indianapolis, IN 46204-2787 Phone: 1-800-452-4800 (toll-free)
Quality Improvement Organization	Health Care Excel, Inc. 2629 Waterfront Parkway, East Drive, Suite 200 Indianapolis, IN 46214 Phone: 1-800-288-1499 (toll-free)/ 1-317-347-4500 (local)/ 1-812-234-1499 (Terre Haute)
State Agency dealing with Advance Directives	Family and Social Services Administration P.O. Box 7083 402 W. Washington Street Indianapolis, IN 46207-7083 (317) 233-4454
State Medicaid Office	Family and Social Services Administration of Indiana 402 West Washington Street P.O. Box 7083 Indianapolis, IN 46207-7083 Phone: 1-800-889-9949 (toll-free)/ 1-317-233-4455 (local)/ 1-317-234-0225 (Spanish)

State	**Iowa**
SHIP Name and Contact Information	Senior Health Insurance Information Program of Iowa (SHIP) 330 Maple Des Moines, IA 50319-0065 Phone: 1-800-351-4664 (toll-free)/ 1-515-281-5705 (local)
Quality Improvement Organization	Iowa Foundation for Medical Care 6000 Westown Parkway, Suite 350 E West Des Moines, IA 50266 Phone: 1-800-752-7014 (toll-free)/ 1-515-223-2900 (local)
State Agency dealing with Advance Directives	Lucas State Office, Bldg. 321 E. 12th Street Des Moines, IA 50319 (515) 281-7689
State Medicaid Office	Department of Human Services of Iowa Hoover State Office Building 5th Floor Des Moines, IA 50319-0114 Phone: 1-800-338-8366 (toll-free)/ 1-515-327-5121 (local)

State	**Kansas**
SHIP Name and Contact Information	Senior Health Insurance Counseling for Kansas (SHICK) 503 S. Kansas Topeka, KS 66603 Phone: 1-800-860-5260 (toll-free)/ 1-316-337-7386 (local)
Quality Improvement Organization	Kansas Foundation for Medical Care 2947 S.W. Wanamaker Drive Topeka, KS 66614 Phone: 1-800-423-0407 (toll-free)/ 1-785-273-2552 (local)
State Agency dealing with Advance Directives	Kansas Department on Aging New England Building 503 S. Kansas Avenue Topeka, KS 66603-3404 (785) 296-4986
State Medicaid Office	Department of Social and Rehabilitation Services of Kansas 915 SW Harrison Street Topeka, KS 66612 Phone: 1-800-766-9012 (toll-free)/ 1-785-274-4200 (local) TTY: 1-785-296-1491

State	**Kentucky**
SHIP Name and Contact Information	Kentucky State Health Insurance Assistance Program 275 East Main Street, 5W-A Frankfort, KY 40621 Phone: 1-877-293-7447 (toll-free)
Quality Improvement Organization	Health Care Excel, Inc. 9300 Shelbyville Road, Suite 600 Louisville, KY 40222 Phone: 1-800-288-1499 (toll-free)/ 1-502-339-7442 (local)
State Agency dealing with Advance Directives	Cabinet for Health and Family Services Office of the Secretary 275 E. Main Street Frankfort, KY 40621 800-372-2973
State Medicaid Office	Cabinet for Health Services of Kentucky P.O. Box 2110 Frankfort, KY 40602-2110 Phone: 1-800-635-2570 (toll-free)/ 1-502-564-4321 (local)

State	**Louisiana**
SHIP Name and Contact Information	Louisiana Senior health Insurance Information Program (SHIP) P.O. Box 94214 Baton Rouge, LA 70804-9214 Phone: 1-800-259-5301 (toll-free: in-state calls only)/1-225-342-5301 (local)
Quality Improvement Organization	Louisiana Health Care Review 8591 United Plaza Blvd., Suite 270 Baton Rouge, LA 70809 Phone: 1-800-433-4958 (toll-free)/1-225-926-6353 (local)
State Agency dealing with Advance Directives	Louisiana Office of Mental Health P.O. Box 4049, Bin #12 Baton Rouge, LA 70821 (225) 342-2540
State Medicaid Office	Louisiana Department of Health and Hospital P.O. Box 91278 Baton Rouge, LA 70821-9278 Phone: 1-888-342-6207 (toll free: in-state calls only)/1-225-342-5774 (local) TTY: 1-225-216-7387

State	**Maine**
SHIP Name and Contact Information	Maine State Health Insurance Assistance Program (SHIP) 11 State House Station 442 Civic Center Drive Augusta, ME 04333-2723 Phone: 1-877-353-3771 (toll-free: in-state calls only)/1-207-621-0087 (local)
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820 Phone: 1-800-772-0151 (toll-free)/ 1-603-749-1641 (local)
State Agency dealing with Advance Directives	207-626-8800
State Medicaid Office	Maine Department of Health and Human Services 442 Civic Center Drive 11 State House Station Augusta, ME 04333-0011 Phone: 1-800-977-6740 (option 2) (toll-free)/ 1-207-624-7539 (eligibility) (local)
State	**Maryland**
SHIP Name and Contact Information	Maryland Senior Health Insurance Assistance Program 301 West Preston Street, Room 1007 State Office Building Baltimore, MD 21201 Phone: 1-800-243-3425 (toll-free: in-state calls only)/1-410-767-1100 (local) TTY: 1-410-767-1083
Quality Improvement Organization	Delmarva Foundation for Medical Care, Inc. 9240 Centreville Road Easton, MD 21601 Phone: 1-800-492-5811 (toll-free)/ 1-410-822-0697 (local)/ 1-800-774-4334 (Spanish)
State Agency dealing with Advance Directives	410-576-6300
State Medicaid Office	Department of Health and Mental Hygiene P.O. Box 17259 Baltimore, MD 21203-7259 Phone: 1-800-492-5231 (toll-free)/ 1-410-767-5800 (local)

State	**Massachusetts**
SHIP Name and Contact Information	Serving Health Information Needs of Elders (SHINE) 1 Ashburton Place, 5th Floor Boston, MA 02108 Phone: 1-800-243-4636 (toll-free)
Quality Improvement Organization	MassPRO 235 Wyman Street Waltham, MA 02451 Phone:1-800-252-5533 (toll-free: in-state calls only)/1-781-890-0011 (local)
State Agency dealing with Advance Directives	617-727-2200
State Medicaid Office	Office of Health and Human Services of Massachusetts 600 Washington Street Boston, MA 02111 Phone: 1-800-325-5231 (toll-free)

State	**Michigan**
SHIP Name and Contact Information	Medicare/Medicaid Assistance Program of Michigan (MMAP) 6105 West St. Joseph, Suite 209 Lansing, MI 48917 Phone: 1-800-803-7174 (toll-free)/ 1-517-886-1242 (local)
Quality Improvement Organization	Michigan Peer Review Organization 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611 Phone: 1-800-365-5899 (toll-free)/ 1-248-465-7300 (local)
State Agency dealing with Advance Directives	Department of Commonwealth Health 6th Floor, Lewis Cass Building 320 South Walnut Street Lansing, MI 48913 (517) 373-3740
State Medicaid Office	Michigan Department of Community Health Sixth Floor, Lewis Cass Building 320 South Walnut Street Lansing, MI 48913 Phone: 1-800-642-3195 (toll free: in-state calls only)/1-517-373-3740 (local)

State	**Minnesota**
SHIP Name and Contact Information	Minnesota SHIP/Senior LinkAge Line 444 Lafayette Road St. Paul, MN 55155 Phone: 1-800-333-2433 (toll-free)
Quality Improvement Organization	Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425 Phone: 1-800-444-3423 (toll-free)/1-952-854-3306 (local)
State Agency dealing with Advance Directives	P.O. Box 64975 St. Paul, MN 55164-0975 (651) 251-5800
State Medicaid Office	Department of Human Services of Minnesota 444 Lafayette Road North St. Paul, MN 55155 Phone: 1-800-657-3739 (toll-free)/ 1-651-431-2670 (local) TTY: 1-651-296-5705
State	**Mississippi**
SHIP Name and Contact Information	Mississippi Insurance Counseling and Assistance Program (MICAP) 750 North State Street Jackson, MS 39202 Phone: 1-800-948-3090 (toll-free)/ 1-601-359-4929 (local)
Quality Improvement Organization	Information and Quality Healthcare 385 Highland Colony Parkway, Suite 120 Ridgeland, MS 39157 Phone: 1-800-844-0600 (toll-free)/ 1-601-957-1575 (local)
State Agency dealing with Advance Directives	Department of Health 570 E. Woodrow Wilson Dr. Jackson, MS 39216 (601) 576-7400
State Medicaid Office	Office of the Governor of Mississippi 239 North Lamar Street, Suite 801 Robert E. Lee Building Jackson, MS 39201-1399 Phone: 1-800-421-2408 (toll-free)/ 1-601-359-6050 (local)

State	**Missouri**
SHIP Name and Contact Information	CLAIM Program of Missouri (SHIP) 3425 Constitution Court, Suite E Jefferson City, MO 65109 Phone: 1-573-817-8320 (local)
Quality Improvement Organization	Primaris 200 North Keene Street Columbia, MO 65201 Phone: 1-800-735-6776 (toll-free)/ 1-573-817-8300 (local)
State Agency dealing with Advance Directives	Division of Health Standards and Licensure Missouri Department of Health P.O. Box 570 912 Wildwood Drive Jefferson City, MO 65102-0570 (573) 751-6400
State Medicaid Office	Department of Social Services of Missouri 221 West High Street P.O. Box 1527 Jefferson City, MO 65102-1527 Phone: 1-800-392-2161 (toll-free: in-state calls only)/1-573-751-4815 (local)

State	**Montana**
SHIP Name and Contact Information	Senior and Long term Care Division of Montana 111 North Sanders Street, PO Box 4210 Room 210 Helena, MT 59604 Phone: 1-800-551-3191 (toll-free: in-state calls only)/1-406-444-7870 (local)
Quality Improvement Organization	Mountain Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 Phone: 1-800-497-8232 (toll-free)/ 1-406-443-4020 (local)
State Agency dealing with Advance Directives	Department of Public Health and Human Services Quality Assurance Division and Licensure Bureau 2401 Colonial Drive, 2nd Floor P.O. Box 202953 Helena, MT 59620-2953 (406) 444-2037
State Medicaid Office	Montana Department of Public Health and Human Services - Division of Child and Adult Health Resources 1400 Broadway, Cogswell Building P.O. Box 8005 Helena, MT 59604-8005 Phone: 1-800-362-8312 (toll-free: in-state calls only)/1-406-444-4540 (local)

State	**Nebraska**
SHIP Name and Contact Information	Nebraska Senior Health Insurance Information Program (SHIIP) 941 O Street, Suite 400 Lincoln, NE 68508 Phone: 1-800-234-7119 (toll-free)/ 1-402-471-2201 (local)
Quality Improvement Organization	Cimro of Nebraska 1230 O Street, Suite 120 Lincoln, NE 68508 Phone: 1-800-247-3004 (toll-free)/ 1-402-476-1399 (local)
State Agency dealing with Advance Directives	Health and Human Services Systems P.O. Box 95044 Lincoln, NE 68509-5044 (402) 471-2306
State Medicaid Office	Nebraska Department of Health and Human Services System P.O. Box 95044 Lincoln, NE 68509-5044 Phone: 1-800-430-3244 (toll-free)/ 1-402-471-3121 (local) TTY: 1-402-471-9570

State	**Nevada**
SHIP Name and Contact Information	State Health Insurance Advisory Program of Nevada 340 North 11th Street, Suite 203 Las Vegas, NV 89101 Phone: 1-800-307-4444 (toll-free)/ 1-702-486-3478 (local)/ 1-702-386-8554 (Spanish)
Quality Improvement Organization	Health Insight 500 S. Rancho Drive, Suite C-17 Las Vegas, NV 89106 Phone: 1-800-748-6773 (toll-free)/ 1-702-385-9933 (local)
State Agency dealing with Advance Directives	Bureau of Licensure and Certification 1550 E. College Parkway Suite 158 Carson City, NV 89706 (775) 687-4475
State Medicaid Office	Nevada Department of Human Resources, Aging Division 1100 East William Street Suite 101 Carson City, NV 89701 Phone: 1-800-992-0900 (toll-free: in-state calls only)/775-684-7200 (local)

State	**New Hampshire**
SHIP Name and Contact Information	Health Insurance Counseling Education and Assistance Services (HICEAS) Attn: HICEAS, 79 Sheep Davis Road PO Box 2338 Concord, NH 03302 Phone: 1-800-852-3388 (toll-free: in-state calls only)/1-603-225-9000 (local)
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820 Phone: 1-800-772-0151 (toll-free)/ 1-603-749-1641 (local)
State Agency dealing with Advance Directives	603-271-3658
State Medicaid Office	New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301-3857 Phone: 1-800-852-3345 x8166 (toll-free: in-state calls only)/1-603-271-4322 (local)
State	**New Jersey**
SHIP Name and Contact Information	New Jersey Department of Health and Senior Services P.O. Box 807 Trenton, NJ 08625-0807 Phone: 1-800-792-8820 (toll-free: in-state calls only) 877-222-3737 (local)
Quality Improvement Organization	Health Care Quality Strategies 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-4026 Phone: 1-800-624-4557 (toll-free: in-state calls only)/1-732-238-5570 (local0
State Agency dealing with Advance Directives	609-292-8740
State Medicaid Office	Department of Human Services of New Jersey Quakerbridge Plaza, Building 7 P.O. Box 712 Trenton, NJ 08625-0712 Phone: 1-800-356-1561 (toll-free: in-state calls only)/1-609-588-2600 (local)/ 1-800-356-1561 (Spanish)

State	**New York**
SHIP Name and Contact Information	Health Insurance Information Counseling and Assistance Program (HIICAP) 1-800-701-0501
Quality Improvement Organization	IPRO Corporate Headquarters 1979 Marcus Avenue Lake Success, NY 11042-1002 Phone: (516) 326-7767 TTY: (516) 326-6182 Fax: (516) 328-2310 support@ipro.us Regional Office 20 Corporate Woods Blvd. Albany, NY 12211-2370 Phone: (518) 426-3300 Fax: (518) 426-3418 support@ipro.us
State Agency dealing with Advance Directives	518-474-7330
State Medicaid Office	New York State Department of Health Corning Tower Empire State Plaza, Albany, NY 12237 1-800-505-5678 (in New York City) 1-888-562-9092 (in Nassau County) 1-888-566-9799 (in Suffolk County)
State	**New Mexico**
SHIP Name and Contact Information	Benefits Counseling Program New Mexico Aging and Long-Term Service Department 2550 Cerrillos Road Santa Fe, NM 87505 Phone: 1-800-432-2080 (toll-free: in-state calls only)/1-505-476-4799 (local)
Quality Improvement Organization	New Mexico Medical Review Association Midtown Center 2340 Menaul, NE, Suite 300 Albuquerque, NM 87107 Phone: 1-800-663-6351 (toll-free)/ 1-505-998-9898 (local)

State Agency dealing with Advance Directives	Department of Health 1190 S. St. Francis Drive Santa Fe, NM 87502 (505) 827-2613
State Medicaid Office	Department of Human Services of New Mexico P.O. Box 2348 Santa Fe, NM 87504-2348 Phone: 1-888-997-2583 (toll-free)/ 1-505-827-3100 (local)/ 1-800-432-6217 (Spanish) TTY: 1-505-827-3184
State	**North Carolina**
SHIP Name and Contact Information	North Carolina Senior Health Insurance Information Program (SHIIP) 111 Seaboard Avenue Raleigh, NC 27604 Phone: 1-800-443-9354 (toll-free: in-state calls only)/1-919-807-6900 (local)
Quality Improvement Organization	Medical Review of North Carolina, Inc. 5625 Dillard Drive, Suite 203 Cary, NC 27511 Phone: 1-800-722-0468 (toll-free)/ 1-919-851-2955 (local)
State Agency dealing with Advance Directives	Division of Public Health North Carolina Department of Health and Human Services 1915 Mall Service Center Raleigh, NC 27699-1915 (919) 733-7081
State Medicaid Office	North Carolina Department of Health and Human Services Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2501 Phone: 1-800-662-7030(toll-free: in-state calls only)/1-919-855-4100 (local)/ 1-919-855-4400 (Spanish) TTY: 1-877-733-4851
State	**North Dakota**
SHIP Name and Contact Information	North Dakota Insurance Department State Capitol, 600 East Blvd., 5th Floor Bismarck, ND 58505 Phone: 1-888-575-6611 (toll-free)/ 1-701-328-2440 (local)

Quality Improvement Organization	North Dakota Health Care Review Inc 800 31st Ave., SW Minot, ND 58701 Phone: 1-888-472-2902 (toll-free)/ 1-800-472-2902 (toll free: in-state only)/ 1-701-852-4231 (local)
State Agency dealing with Advance Directives	North Dakota Department of Health 600 E. Boulevard Avenue Bismarck, ND 58505 (701) 328-2352
State Medicaid Office	Department of Human Services of North Dakota Medical Services 600 East Blvd. Ave Bismarck, ND 58505-0250 Phone: 1-800-755-2604 (toll-free)/ 1-701-328-2321 (local) TTY: 1-701-328-8950
State	**Ohio**
SHIP Name and Contact Information	Senior Health Insurance Information Program of Ohio (SHIP) 2100 Stella Court Columbus, OH 43215-1067 Phone: 1-800-686-1578 (toll-free)/ 1-614-644-3458 (local) TTY: 1-614-644-3745
Quality Improvement Organization	Ohio KePRO Inc. Rock Run Center 5700 Lombardo Center Drive, Suite 100 Seven Hills, OH 44131 Phone: 1-800-589-7337 (toll-free)/ 1-216-447-9604 (local)/ 1-800-633-4227 (Spanish)
State Agency dealing with Advance Directives	Ohio Department of Health 246 N. High Street P.O. Box 118 Columbus, OH 43216-0118
State Medicaid Office	Department of Job and Family Services of Ohio Ohio Health Plans 30 East Broad Street, 31st Floor Columbus, OH 43215-3414 Phone: 800-324-8680 (toll-free)/ 1-614-728-3288 (local)

State	**Oklahoma**
SHIP Name and Contact Information	Oklahoma Senior Health Insurance Counseling Program (SHICP) 2401 N.W. 23rd, Suite 28 Oklahoma City, OK 73107 Phone: 1-800-763-2828 (toll-free: in-state calls only)/1-405-521-6628 (local)
Quality Improvement Organization	Oklahoma Foundation for Medical Quality, Inc. 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134 Phone: 1-405-840-2891 (local)
State Agency dealing with Advance Directives	Oklahoma State Department of Health 1000 N.E. 10th Street Oklahoma City, OK 73117 (405) 271-5600
State Medicaid Office	Health Care Authority of Oklahoma 4545 N. Lincoln Blvd. Suite 124 Oklahoma City, OK 73105 Phone: 1-800-522-0310 (toll-free)/ 1-405-522-7171 (also 1-405-522-7300) (local) TTY: 1-405-522-7179

State	**Oregon**
SHIP Name and Contact Information	Oregon Senior Health Insurance Benefits Assistance (SHIBA) PO Box 14480 Salem, OR 97309-0405 Phone: 1-800-722-4134 (toll free: in-state calls only)/1-503-378-2014 (local) TTY: 1-503-947-7280
Quality Improvement Organization	Oregon Medical Professional Review Organization (OMPRO) 2020 SW Fourth Ave., Suite 520 Portland, OR 97201 Phone: 1-800-344-4354 (toll-free)/ 1-503-279-0100 (local)
State Agency dealing with Advance Directives	503-378-4732
State Medicaid Office	Oregon Department of Human Services 500 Summer Street, NE, 3rd Floor Salem, OR 94310-1014 Phone: 1-800-527-5772 (toll-free: in-state calls only)/1-503-945-5772 (local) TTY: 1-503-945-5895

State	**Pennsylvania**
SHIP Name and Contact Information	APPRISE 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 Phone: 1-800-783-7067 (toll-free)/ 1-717-783-8975 (local)
Quality Improvement Organization	Quality Insights of Pennsylvania 2601 Market Place Street, Suite 320 Harrisburg, PA 17110 Phone: 1-877-346-6180 (toll-free)/ 1-304-346-9864 (local)
State Agency dealing with Advance Directives	Department of Health Health and Welfare Building, P.O. Box 90 Harrisburg, PA 17108 Phone: 1-877-PA-HEALTH
State Medicaid Office	Department of Public Welfare of Pennsylvania Health and Welfare Building, Rm. 515 P.O. Box 2675 Harrisburg, PA 17105 Phone: 1-800-692-7462 (toll-free)/ 1-717-787-1870 (local) TTY: 1-717-705-7103

State	**Rhode Island**
SHIP Name and Contact Information	Rhode Island Senior Health Insurance Program (SHIP) Benjamin Rush Building, #55 35 Howard Avenue Cranston, RI 02920 Phone: 1-401-462-4444 (local) TTY: 1-401-462-0740
Quality Improvement Organization	Rhode Island Quality Partners Inc. 235 Promenade Street, Suite 500 Box 18 Providence, RI 02908 Phone: 1-800-662-5028 (toll-free)/ 1-401-528-3200 (local)
State Agency dealing with Advance Directives	401-274-4400
State Medicaid Office	Department of Human Services of Rhode Island Louis Pasteur Building 600 New London Avenue Cranston, RI 02921 Phone: 1-800-984-8989 (toll-free: in-state calls only)/1-401-462-5300 (local) TTY: 1-401-462-3363

State	**South Carolina**
SHIP Name and Contact Information	Bureau of Senior Services of South Carolina Jefferson Square Building PO Box 8206 Columbia, SC 29202-8206 Phone: 1-800-868-9095 (toll-free)/ 1-803-734-9900 (local)
Quality Improvement Organization	Carolina Center for Medical Excellence 250 Berryhill Road, Suite 101 Columbia, SC 29210 Phone: 1-800-922-3089 (toll free: in-state calls only)/ 1-803-251-2215 (local)
State Agency dealing with Advance Directives	Bureau of Certification South Carolina Department of Health and Environmental Control 2600 Bull Street Columbia, SC 29201 (803) 898-2500
State Medicaid Office	South Carolina Department of Health & Human Services P.O. Box 8206 Columbia, SC 29202-8206 Phone: 1-888-549-0820 (toll-free)/ 1-803-898-2500(local)
State	**South Dakota**
SHIP Name and Contact Information	Adult Services and Aging of South Dakota 700 Governors Drive Pierre, SD 57501 Phone: 1-800-536-8197 (toll-free)/ 1-605-773-3656 (local) TTY: 1-605-367-5760
Quality Improvement Organization	South Dakota Foundation for Medical Care, Inc. 1323 South Minnesota Avenue Sioux Falls, SD 57105 Phone: 1-800-658-2285 (toll-free)/ 1-605-336-3505 (local)
State Agency dealing with Advance Directives	Department of Social Services 700 Governor s Drive Pierre, SD 57501 (605) 773-3165
State Medicaid Office	Department of Social Services of South Dakota 700 Governors Drive Richard F Kneip Building Pierre, SD 57501 Phone: 1-800-452-7691 (toll-free: in-state calls only)/1-605-773-3495 (local)/ 1-800-305-9673 (Spanish)

State	**Tennessee**
SHIP Name and Contact Information	Tennessee Commission on Aging and Disability 2670 Union Ave. 10th Floor, Suite 1000 Memphis, TN 38112 Phone: 1-877-801-0044 (toll-free) TTY: 1-615-532-3893
Quality Improvement Organization	Foundation for Medical Care Inc. of the Mid South 3175 Lenox Park Blvd., Suite 309 Memphis, TN 38115 Phone: 1-800-489-4633 (toll-free)/ 1-901-682-0381 (local)
State Agency dealing with Advance Directives	Division of Health Care Facilities Tennessee Department of Health Cordell Hull Bldg., 1st Floor 426 Fifth Ave., North Nashville, TN 37247 (615) 741-7221 or 1-800-778-4504
State Medicaid Office	Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 Phone: 1-866-311-4287 (toll-free)

State	**Texas**
SHIP Name and Contact Information	Department of Aging and Disabilities Services 4900 N Lamar, 4th Floor Austin, TX 78751 Phone: 1-/800-252-9240 (toll-free)
Quality Improvement Organization	Texas Medical Foundation Barton Oaks Plaza Two, Suite 200 901 Mopac Expressway South Austin, TX 78746-5799 Phone: 1-800-725-8315 (toll-free) or 1-512-329-6610 (local)
State Agency dealing with Advance Directives	Department of Aging and Disability 701 W.51st Street Austin, TX 78751 (512) 438-3011
State Medicaid Office	Health and Human Services Commission of Texas 4900 N. Lamar Blvd 4th Floor Austin, TX 78701 Phone: 1-877-541-7905 (toll-free: in-state calls only)/1-512-424-6500 (local) TTY: 1-512-407-3250

State	**Utah**
SHIP Name and Contact Information	Aging and Adult Services of Utah 120 North 200 West, Suite 325 Salt Lake City, UT 84103 Phone: 1-800-541-7735 (toll-free: in-state calls only)/1-801-538-3910 (local)
Quality Improvement Organization	HealthInsight 348 E 4500 South, Suite 300 Salt Lake City, UT 84107 Phone: 1-800-274-2290 (toll-free)/ 1-801-892-0155 (local)
State Agency dealing with Advance Directives	Medicare/Medicaid Program Cert/Resident Assessment Division of Health Systems Improvement P.O. Box 16990 Salt Lake City, UT 84114 (801) 538-6101
State Medicaid Office	Utah Department of Health 288 North 1460 West P.O. Box 143101 Salt Lake City, UT 84114-3101 Phone: 1-800-662-9651 (toll-free)/ 1-801-538-6155 (local)/ 1-800-662-9651 (Spanish)

State	**Vermont**
SHIP Name and Contact Information	Area Agency on Aging of Vermont 1161 Portland Street St. Johnsbury, VT 05819 Phone: 1-800-642-5119 (toll-free: in-state calls only)/1-802-748-5182 (local)
Quality Improvement Organization	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820 Phone: 1-800-772-0151 (toll-free)/ 1-603-749-1641 (local)
State Agency dealing with Advance Directives	802-828-3173
State Medicaid Office	Agency of Human Services of Vermont 103 South Main Street Waterbury, VT 05676-1201 Phone: 1-800-250-8427 (toll-free: in-state calls only)/1-802-879-5900 (local) TTY: 1-802-241-1282

State	**Virginia**
SHIP Name and Contact Information	Virginia Insurance Counseling and Assistance Program (VICAP) 1600 Forest Avenue, Preston Building, Suite 102 Richmond, VA 23229 Phone: 1-800-552-3402 (toll-free)/ 1-804-662-9333 (local)
Quality Improvement Organization	Virginia Health Quality Center 4510 Cox Road, Suite 400 Glen Allen, VA 23060 Phone: 1-800-545-3814 (toll-free)/ 1-804-289-5320 (or 1-804-289-5397) (local)
State Agency dealing with Advance Directives	Virginia Dept. of Health P.O. Box 2448 Richmond, VA 23218 Phone: 1-804-864-7147
State Medicaid Office	Department of Medical Assistance Services 600 East Broad Street Suite 1300 Richmond, VA 23219 Phone: 1-804-786-7933 (local)
State	**Washington**
SHIP Name and Contact Information	Statewide Health Insurance Benefits Advisors of Washington P.O. Box 45600 Olympia, WA 98504 Phone: 1-800-562-6900 (toll-free)/ 1-360-725-7073 (local)/ 1-800-562-6900 (Spanish) TTY: 1-360-586-0241
Quality Improvement Organization	QualisHealth 10700 Meridian Ave. North, Suite 100 Seattle, WA 98133 Phone: 1-877-575-8309 (toll-free)/ 1-206-364-9700 or 1-206-368-8272 (local)
State Agency dealing with Advance Directives	360-753-6200
State Medicaid Office	Department of Social and Health Services of Washington P.O. Box 45505 Olympia, WA 98504-5505 Phone: 1-800-562-3022 (toll-free: in-state calls only)/1-800-562-6188 (local)

State	**Washington, D.C.**
SHIP Name and Contact Information	Washington, D.C. Health Insurance Counseling Project (HICAP) 2136 Pennsylvania Ave., NW Washington, DC 20052 Phone: 1-202-739-0668 (local)/ 1-202-739-0668 (Spanish) TTY: 1-202-973-1079
Quality Improvement Organization	Delmarva Foundation for Medical Care, Inc. 1620 L Street, NW, Suite 1275 Washington, DC 20036 1-800-999-3362 (or 1-800-492-5811)(toll-free)/ 1-202-293-9650 (or 1-410-822-0697) (local)
State Agency dealing with Advance Directives	202-724-1305
State Medicaid Office	DC Healthy Family 825 North Capitol Street, NE 5th Floor Washington, DC 20002 Phone: 1-888-557-1116 (toll-free)/ 1-202-742-5506 (local) TTY: 1-202-639-4041
State	**West Virginia**
SHIP Name and Contact Information	Bureau of Senior Services of West Virginia 1900 Kanawha Blvd. Building 10 Charleston, WV 25305 Phone: 1-877-987-4463 (toll-free)/ 1-304-558-3317 (local)
Quality Improvement Organization	West Virginia Medical Institute, Inc. 3001 Chesterfield Place Charleston, WV 25304 Phone: 1-800-642-8686 ext 266 (toll-free)/ 1-304-346-9864 (local)
State Agency dealing with Advance Directives	Department of Health and Human Resources State Capitol Complex Bldg. 3 Room 206 Charleston, WV 25305 Phone: 1-800-642-8686 ext 266 (toll-free)/ 1-304-346-9864 (local)
State Medicaid Office	West Virginia Department of Health and Human Resources 350 Capitol Street, Room 251 Charleston, WV 25301-3709 (304) 558-1700

State	**Wisconsin**
SHIP Name and Contact Information	State Health Insurance Assistance Program of Wisconsin 214 North Hamilton Street Madison, WI 53703-2118 Phone: 800-242-1060 (toll-free)/ 1-888-701-1255 (Spanish)
Quality Improvement Organization	MetaStar Inc. 2909 Landmark Place Madison, WI 53713 Phone: 1-800-362-2320 (toll-free)/ 1-608-274-1940 (local)
State Agency dealing with Advance Directives	Department of Health and Family Services 1 W. Wilson Street Madison, WI 53702 (608) 266-1865
State Medicaid Office	Wisconsin Department of Health and Family Services 1 West Wilson Street P.O. Box 309 Madison, WI 53701-0309 Phone: 1-800-362-3002 (toll-free)/ 1-608-221-5720 (local) TTY: 1-608-267-7371

State	**Wyoming**
SHIP Name and Contact Information	State Health Insurance Information Program of Wyoming (SHIP) 122 W, 25th Street, Hershler, 3rd Floor East Cheyenne, WY 82002 Phone: 1-800-856-4398 (toll-free)
Quality Improvement Organization	Mountain Pacific Health Foundation 1950 Bluegrass Circle, Suite 280 Cheyenne, WY 82009 Phone: 1-800-497-8232 (toll-free)/ 1-406-443-4020 (local)
State Agency dealing with Advance Directives	Wyoming Department of Public Health Mental Health Division 6101 Yellowstone Rd. Room 259 B Cheyenne, WY 82002 (307) 777-7094
State Medicaid Office	Wyoming Department of Health 147 Hathaway Building Cheyenne, WY 82002 Phone: 1-307-777-7531 (local) TTY: 1-307-777-5648

State	**Puerto Rico**
SHIP Name and Contact Information	QIPRO Mercantile Plaza Building Suite 605 Hato Rey, PR 00918 (787) 641-1240
Quality Improvement Organization	Health Services Advisory Group, Inc. 1600 East Northern Ave., Suite 100 Phoenix, AZ 85020-3933 Phone: 800-359-9909 (toll free)/ 602-264-6382 (local)
State Agency dealing with Advance Directives	QIPRO Mercantile Plaza Building Suite 605 Hato Rey, PR 00918 (787) 641-1240
State Medicaid Office	Medicaid Office of Puerto Rico And Virgin Islands, GPO Box 70184 San Juan, PR 00936 (787) 765-1230

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